

INSTRUCTIONS: Please complete and fax this page to **1-866-850-9155**.

1 PATIENT INFORMATION

First Name:		Address:	
Last Name:		City:	
Last 4 Digits of the SSN:	DOB: / /	State:	Zip:
Legal US Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Preferred Phone:	
Email:		Best Time to Contact: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	

2 INSURANCE INFORMATION

<input type="checkbox"/> Patient does not have insurance	Medical Insurance Name:	Pharmacy Insurance Name:
Phone:	Member ID #:	Phone: Pharmacy ID:
Policyholder Name & DOB: / /		BIN: PCN:
<input type="checkbox"/> See secondary insurance information attached. (NOTE: Be sure to include secondary insurance information when sending back these forms)		

3 MEDICAL HISTORY (PLEASE INCLUDE ICD-10 CODE)

Diagnosis Code Category:	<input type="checkbox"/> Diagnosis (ICD-10): _____	<input type="checkbox"/> Other Diagnosis:	Allergies:
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4 PRESCRIPTION FOR SUCRAID[®]

<input type="checkbox"/> Take 1 mL by mouth with every meal or snack up to 8 times per day for a 30-day supply (<15 kg). Dispense two bottles. Number of refills _____ <input type="checkbox"/> Dispense as written Prescriber Signature: _____ Date: _____	<input type="checkbox"/> Take 2 mL by mouth with every meal or snack up to 6 times per day for a 30-day supply (>15 kg). Dispense three bottles. Number of refills _____ <input type="checkbox"/> Substitution allowed Prescriber Signature: _____ Date: _____	<input type="checkbox"/> Take ____ mL by mouth with every meal or snack up to ____ times per day for a 30-day supply (>15 kg). Dispense ____ bottles. Number of refills _____ I authorize US Bioservices to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.
Please attach a separate prescription if this section does not comply with your state's prescription law. Prescriptions from New York must be issued electronically.		

5 PRESCRIBER INFORMATION

Prescriber Name:		NPI #:	
*Collaborating Physician Name:		NPI #:	
Facility Name:		State License #:	
Address:	City:	State:	Zip:
Phone:	Contact Email:		
Office Contact Name:	Office Contact Phone:	Office Contact Fax:	

*Collaborating Physician Name and NPI# Only in Applicable States

NOTE: Original signature required - If required by applicable law, please attach copies of all prescriptions on official state prescription forms.