PRESCRIPTION AND ENROLLMENT FORM

PHONE: 800-361-1260
FAX: 800-737-4920

CORNERSTONE PHARMACY
an affiliate of
MEDICAL CENTRE PHARMACY

Ordering Medications is as easy as *1 – 2 – 3*

(1) Complete the patient information below.

PATIENT INFORMATION (PLEASE PRINT)		
Patient Name (Last, First, Mi)	Phone (Daytime)	Date of Birth (mm/dd/yyyy)
Street Address (Please include Suite/Apt Number)		
City	State	Zip
Patient Weight: _____ lbs. OR _____ kg.	**Drug Allergies:** _____ ☐ NKDA	
DIAGNOSIS / MEDICAL INFORMATION (Please indicate primary and secondary diagnosis)		
☐ ICD Code & Name: _____	☐ ICD Code & Name: _____	Is patient new to therapy? ☐ yes ☐ no Date of Diagnosis:

(2) Photocopy FRONT and BACK of Patient's insurance card(s).

(3) Tape prescription below and FAX this form and the insurance card photocopies.

Cornerstone Pharmacy does the rest. We coordinate the insurance pre-authorization, patient co-pay, delivery to the patient's home or physician's office and patient assistance programs.

Tape
Prescription
Here