PRESCRIPTION AND ENROLLMENT FORM

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

CORNERSTONE PHARMACY
an affiliate of

PATIENT INFORMATION				
Patient Name (Last, First, Mi)			☐ Male ☐ Female	
Date of Birth	**SS#**	Phone (Home)	(Work)	
Address		City	State	Zip

INSURANCE INFORMATION (PLEASE ATTACH COPY OF PATIENT CARD – FRONT AND BACK)		
Primary Insurance		Policy Holder
Policy #	Group #	Phone

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: _____/_____/_____
Patient Weight: _____	Drug Allergies: _____ OR ☐ NKDA	

PREVIOUS MEDICATIONS (Please specify dosage and time on therapy)

Medication Strength and Dose	*Date of Therapy*	*Reason for Discontinuing*

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	SIG / DIRECTIONS	QUANITY	REFILLS

DELIVERY AND PATIENT EDUCATION INSTRUCTIONS			
☐ Patient's Home	☐ Physician's Office	Date Needed	Patient needs Education Kit? ☐ yes ☐ no
Teaching to be done at:	☐ Patient's Home		
	☐ Physician's Office	☐ Not needed	

PHYSICIAN CONTACT INFORMATION AND AUTHORIZATION				
Physician Name		License #	DEA #	UPIN#
Office Contact	Phone	Fax	NPI#	
Address		City/State/Zip		
Physician's Signature (required)		Date (required)		
This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.				