



Community Consultant Contact:

PRESCRIPTION REFERRAL FORM

Fax referral to: 844-814-1944 Phone: 844-814-1943
Email referral form to: connect@realospecialtycare.com
For additional forms, visit realospecialtycare.com.

PATIENT INFORMATION

Patient Name: _____ Male Female SS#: _____ DOB: _____
 Address: _____ City, State, Zip: _____
 Primary Phone: _____ Home Cell Work Alternate Phone: _____ Home Cell Work
 Email: _____ Height: _____ Weight: _____
 Allergies: _____ Comorbidities: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Office Contact: _____
 Address: _____ City, State, Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____

SHIPPING INFORMATION

Ship To: Patient Physician/Clinic Realo Location: _____
 Date Shipment Needed By: _____ Alternate Location: _____
Shipping Address City, State, Zip

DIAGNOSIS AND CLINICAL INFORMATION (Please fax recent clinical notes, labs, and tests to expedite PA)

Diagnosis / ICD-10: _____
 Pertinent Lab Information: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE	QUANTITY	REFILLS

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Dispense As Written - Signature	Date	Substitution Permissible - Signature	Date

PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.

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