PRESCRIPTION REFERRAL FORM

REALO SPECIALTY CARE PHARMACY

Community Consultant Contact:

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 Permissable - Signature	Date

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