VERBAL ORDER FORM
INTERNAL MEDICINE

PFSP
@pfsprx #pfsprx

398 W. Grand Avenue | Rahway, NJ 07065
Ph 844-527-9486 | Fx 866-285-7628
NPI# 1669881777 NABP# 3148839
info@pfsprx.com PFSPrx.com

Today's Date _____
Date Needed _____

urac ACCREDITED
Rare Disease Pharmacy Center of Excellence
Expires 07/01/2023

☐ Phone Order
Ship to Patient: ☐ Home ☐ Work
Ship to: ☐ Physician Office
☐ Nurse / Training
☐ PFSP Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State_____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____

Primary Insurance_____ ID#_____ Group #_____
Insured's Name_____ Employer_____
City_____ State_____ Phone_____

ICD-10 Diagnosis Code: ☐ E78.5 Unspecified Hyperlipidemia ☐ E78.0 Pure Hypercholesterolemia ☐ E08.9 Diabetes Mellitus without complications ☐ E08.8 Diabetes Mellitus with unspecified complications ☐ M81.0 Age-related Osteoporosis ☐ K58.0 IBS-D ☐ K59.0 Constipation ☐ _____
Patient currently on therapy? ☐ Yes ☐ No Type/medication(s) _____
Will patient stop taking the medication(s) before starting the new medication? ☐ Yes ☐ No
If yes, how long should patient wait before starting the new medication? _____
Current medications patient (including OTC) with dosage and direction (or fax medication) _____

Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed _____
PPD (TB Test) ☐ Yes ☐ No Date_____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **DUPIXENT** ☐ 300mg/mL PFS ☐ 200mg/1.14mL PFS
☐ Asthma Starter: Inject 400mg SQ on Day 1, then 200mg SQ every other week. QTY: 4 PFS Refills: 0
Maint: Inject 200mg SQ every other week. QTY: 2 PFS Refills: ____
☐ Asthma Starter: Inject 600mg SQ on Day 1, then 300mg SQ every other week. Qty: 4 PFS Refills: 0
Maint: Inject 300mg SQ every other week. Qty: 2 PFS Refills: _____
☐ Sharps Container ☐ If applicable, enroll patient in *MyWay*™

☐ **REPATHA®** ☐ Auto-Injector 140MG ☐ PFS 140MG
SIG: ☐ 140MG SC every 2 weeks ☐ 420MG SC once monthly
☐ Other: _____ QTY:_____ Refill:_____

☐ **PRAULENT®**
☐ Pen 150MG ☐ PFS 150MG ☐ Pen 75MG ☐ PFS 75MG
SIG: ☐ 75MG once every 2 weeks ☐ 150MG once every 2 weeks
QTY:_____ Refill:_____

☐ **OTEZLA®** ☐ 30mg twice daily (recommended) ☐ 30mg daily (for severe renal impairment)
Starter Pack:
☐ Two-week Starter Pack Date Prescriber Provided:_____
☐ 28 Day Starter Pack SIG: Take as directed QTY: 55 Refill: 0
Maintenance:
☐ SIG: Take one tablet by mouth twice daily QTY: 60 Refill: _____
☐ SIG: Take one tablet by mouth daily QTY: 30 Refill: _____
☐ If applicable, enroll in Otezla SupportPlus™ ☐ If applicable, enroll in Bridge RX Program

☐ **VIBERZI®** ☐100mg ☐75mg QTY:_60_ Refill:_____
SIG: Take 1 tablet by mouth twice daily with food.

☐ **XIFAXAN®** (RIFAXIMIN) ☐ 550mg TABLET
SIG: ☐1 550mg TAB PO TID x 14 Days QTY:_42_ Refill:_____
☐1 550mg TAB PO BID QTY:_60_ Refill:_____

☐ **RELISTOR®** ☐ 8mg PFS ☐12mg PFS ☐150mg TABLET
SIG: _____ QTY:_____ Refill:_____

☐ **TRULANCE®** 3mg tablet *(for CIC and IBS-C)*
SIG: ☐ Take 1 tablet by mouth with or without food daily
QTY:_____ Refill:_____

☐ **LUCEMYRA™** 0.18mg TABLET
SIG: ☐ Take 3 tablets (0.54mg) by mouth every 5-6 hours during peak withdrawal symptoms for up to 14 days. QTY:_____ Refill:_____
☐ Other: _____ QTY:_____ Refill:_____

☐ **PROLIA®** 60mg PFS
SIG: Inject 60mg subcutaneously every 6 months QTY: 1 Refill:_____

☐ **EVENITY®** 105mg/1.17mL PFS (2-count)
SIG: Inject 210mg (two 105mg PFS) under the skin once monthly for 12 months.
Qty: ☐ 2 PFS (1 month) ☐ 6 PFS (3 months) Refills: _____

☐ **TYMLOS™** ☐ 1.56 mL Prefilled Multi-Dose Pen
SIG: Inject 80mcg subcutaneously once a day
QTY: 1 pen (30 day supply) Refill:_____

☐ **DIFICID®** 200mg TABLET QTY:_20_ Refill:_____
SIG: Take one tablet orally twice daily for 10 days with or without food

☐ **DUEXIS®** 800 mg Ibuprofen/26.6 mg Famotidine
SIG: Take 1 tab orally 3x per day QTY:_____ Refill:_____

☐ **VIMOVO®** ☐ 375 mg/20 mg ☐ 500 mg/20 mg
SIG: 1 tablet 2x daily QTY:_____ Refill:_____

☐ **PENNSAID® 2%** QTY:_____ Refill:_____
SIG: 40 mg (2 pump actuations) on each painful knee, 2x daily.

☐ **FORTEO®** 600MCG/2.4mL
SIG: Inject 20mcg SQ Daily as directed
QTY: ☐ 1 pen (4 wk supply) ☐ 3 pens (12 wk supply) Refill:_____

ADVOCATE ULTRA-FINE PEN NEEDLES ☐ Short 8mm 31G ☐ Mini 5mm 31G
SIG: _____ QTY: 1 Box Refill:_____

OTHER _____
SIG: _____ QTY:_____ Refill:_____

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State_____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____
Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

Please fax completed referral form to **PFSP** at **866-285-7628**
Visit us at **PFSPrx.com** for online fillable forms.
Scan our QR Code to send us feedback about your experience.