Publix Specialty Pharmacy #3213
PRESCRIPTION REFERRAL FORM

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: __________________________ Patient's Last Name: ___________________________ Date of Birth: ___/___/_____ ☐ Male ☐ Female

Address: ____ City: ___________________________ State: ___________ Zip: __________________

Primary Phone Number: (_____) _______________ Alt. Phone Number: (_____) ____________________ Caregiver name: ___________________________

Clinical Information [Attach copy of labs and clinical notes]

Primary Diagnosis: ____ Diagnosis code: _________________________

Secondary Diagnosis: ____ Diagnosis code: _________________________

Treatment status: ☐ New to therapy ☐ Continuation of therapy, start date: ___/___/_____ Is the patient on samples? ☐ Yes ☐ No

Allergies: ☐ NKDA ☐ Other: ____ Weight: _____☐ kg ☐ lb, Height: _____☐ cm ☐ in

Other pertinent past medical history and/or drug therapy: ____

____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS

Prescriber Information

Ship to prescriber: ☐ Never ☐ Always ☐ First fill only, appointment date: ___/___/_____ Using Cover My Meds: ☐ No ☐ Yes

Name: ____ DEA# ________________________ NPI # _______________________________________

Address: ____ City: ___________________________ State: ___________ Zip: __________________

Office Phone Number: (_____) ________________ Fax Number: (_____) _______________________ Office Contact: ______________________________

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: (stamps not accepted) _____________________________________ ☐ Substitution allowed Date

_____________________________________ ☐ Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here:

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