

**Fairview Specialty Pharmacy**  
**Phone: 1-877-522-1340 / Fax: 1-877-596-8488**

**PATIENT INFORMATION** (Please type or print clearly)

Last Name	First Name	Middle Initial
Date of Birth		Preferred Contact Number w/area code

**PRIMARY INSURANCE** (Please attach a copy of card(s) if possible)

Cardholder ID#
Group/Policy #

**MEDICAL ASSESSMENT**

Medication Allergies	
Primary Diagnosis	ICD-9 Code

**PROVIDER INFORMATION**

Prescriber's Name (Print)	
Prescriber's NPI	Prescriber's Phone:

**PRESCRIPTION INFORMATION**

Medication/Dose		
Directions		
Qty	Refill <input type="checkbox"/> 12 Months	<input type="checkbox"/> Refill _____ Times
Prescriber's Signature		Date
Form Faxed by	Phone	

[www.fairview.org/Pharmacy/Specialty\\_Pharmacy](http://www.fairview.org/Pharmacy/Specialty_Pharmacy)

