Prescription Transfer Form

PATIENT INFORMATION

Patient Name: ______________________________
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: ______________________________
City: ____________________ State: ________ Zip: ______________
Phone: (_____) - _____ - ________
Email: ______________________________
Preferred method of contact: ☐ Phone ☐ Email
Height: ________ in Weight: ________ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: __________________ ID#: ________________________ Group #: ______________ RxBIN: _________ RxPCN: _________

PRESCRIBER INFORMATION

Prescriber Name: ______________________________
Address: ______________________________
City: ____________________ State: ________ Zip: ______________
Contact: _______________ Clinic/Hospital Affiliation: _______________
Phone: (_____) - _____ - ________ Fax: (_____) - _____ - ________
License #: ______________________________
NPI #: ______________________________
Medicaid Provider #: ______________________________

PTRX-20-01

PHARMACY INFORMATION

Prescriber Name: ______________________________
Address: ______________________________
City: _____________ State: _____ Zip: ______________
Transferring RPh Name: ____________________________
Phone: (____) - ____ - ________
Fax: (____) - ____ - ________
NPI #: _________________________

CLINICAL CONSIDERATIONS

Diagnosis: _________________________
ICD10: _________________________

℞

Rx Number	Medication	Dose/Strength	Directions	Quantity	Refills

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: _____ / _____ / _____

PHONE: 855-726-8479 (412-246-9858) **FAX**: 855-246-3986 (412-787-9400) **www.pantherxrare.com**

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