BERGEN AVE DRUGS

ENDOCRINOLOGY REFERRAL FORM

745 Bergen Ave | Jersey City, NJ, 07306 Tel 201.521.0545 | Fax 201.521.0546

Today's Date	Anticipated Start	Date

NEW PATIENT

Specialty Pharmacy

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Last updated: May 2017

CURRENT PATIENT

Patient Name_Fir	st Name	Middle Name	Lo	ıst Name	DOB_	Weight	Last updated: May 2017 Male Female
Daytime Tel	Evening Tel	Cell _		Email			
Ship to Patient at	☐ Home ☐ Work OR	Patient will pick up at	Physicia	n Office 🔲 Pharm	acy Date	Needed	
Primary ICD-10 Co	odeSeco	ondary ICD-10 Code		Is patient new to	therapy? 🗆 N	lo □ Yes Date of Di	agnosis
Insured's Name_		Relation to Po	atient	Eligible	for Medicare	Yes No If yes, N	Medicare#
Prescription Card	Yes No If Yes, Carrie	er Tel _		Fax		Policy/Group#	
Bin#	Pcn#	<u> </u>	R>	(ID#	RX Gro	oup#	
Prescriber's Name				Office Contac	t		
Street Address			Suite #	City		State	Zip
	Fax						
License#	NPI#		UF	PIN#		_ DEA#	
PRESCRIP'	TION			PLEASE A	TTACH COP	IES OF PATIENT'S	INSURANCE CARDS
GENOTROPII	N Dose/Frequency/Route			REPATHA® (EVOLO	CUMAB) 140	mg/ml_single-use prefilled	SureClick® autoinjector
	Refill:			SIG: Inject 140 mg subcutaneously every 2 weeks QTY: 1 month supply 3 month supply Other Refills Refills			
HUMATROPE Sig	Dose/Frequency/Route			THYROGEN® (THY			
	Refill:			Dose/Frequency/Ro	oute		
NORDITROPI	N Dose/Frequency/Route					Refills	
Qty	Refill:	S		CORTROSYN® (C	OSYNTROPIN FOR	R INJECTION) 	
OMNITROPE Sig	Dose/Frequency/Route			Sig		_ Refills	
Qty	Refill:	S					
SAILEN	Dose/Frequency/Route			1 310			
Qty	Refills	 S		Qty		Refills	
TEV-TROPIN	Dose/Frequency/Route			PLEASE LIST AND	CILLARY SUPP	LIES IF NEEDED	
Sig Qty	Refill:	S					
	^{en)} Inject 20mg SQ Daily (☐ ENROLL IN N	URSE TRAININ	G / MANUFACTURE	R PROGRAM

Prescriber's Signature (signature required. NO STAMPS)

____ Date ____

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