



Medication Request

Pharmacy: 1-813-960-2020

Toll Free: 1-877-436-2020

Fax Prescription to: 1-813-549-3810

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Diagnosis: _____

<u>#/Size</u>	<u>Medication/Strength/Dosage/Form</u>	<u>SIG</u>	<u>Refills</u>

ID# _____ GRP# _____ PCN# _____ BIN# _____

Insurance Phone # _____ Medically Necessary: _____

Prescriber Signature: _____ Date: ___/___/___

Physician Name: _____ Office Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Lic#: _____ DEA#(required only for scheduled medications) _____

*This Rx Pad was provided courtesy of Superior Specialty Pharmacy. Valid only at Superior Specialty Pharmacy with signature.

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