Legacy Specialty Pharmacy

Your partner in Specialty Care

GENERAL REFERRAL FORM

PROVIDER / PRESCRIBER INFORMATION			
Please sign and fax the completed form to (832) 213 - 0157			With any questions, please call us at (713) 665 – 8800
SHIP TO			**NEEDS BY DATE**
☐ Patient	☐ Office	☐ Other: _____	

PRESCRIBER NAME	SPECIALTY	NPI NUMBER

ADDRESS	CITY/STATE	ZIPCODE

OFFICE CONTACT	PHONE NUMBER	FAX NUMBER

PATIENT INFORMATION *(Person receiving care)*

PATIENT FIRST NAME	PATIENT MIDDLE NAME	PATIENT LAST NAME

AFFIRMED NAME (IF APPLICABLE)	DATE OF BIRTH	SEX (AT BIRTH)
		☐ Male ☐ Female

ADDRESS	CITY/STATE	ZIPCODE

MAIN PHONE NUMBER	OTHER PHONE NUMBER
☐ Home Phone ☐ Mobile Phone	☐ Home Phone ☐ Mobile Phone

LANGUAGE		
☐ English	☐ Spanish	☐ Other: _____

INSURANCE INFORMATION *(Attach a copy of insurance card including front and back)*

POLICY HOLDER	POLICY HOLDER DATE OF BIRTH	MEMBER ID NUMBER

GROUP NUMBER	PHONE NUMBER	PRIOR AUTHORIZATION REF #

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MEDICAL INFORMATION *(Attach copy of clinical notes and labs)*

PRIMARY DIAGNOSIS	PRIMARY ICD-10 CODE	PRIMARY DIAGNOSIS DATE
OTHER DIAGNOSIS	**OTHER ICD-10 CODE**	**OTHER DIAGNOSIS DATE**

WEIGHT	HEIGHT	LABS
☐ kg ☐ lb	☐ cm ☐ in	

ALLERGIES

PREVIOUS MEDICATIONS USED TO TREAT DIAGNOSIS OR CONDITION

MEDICATION NAME & DOSE	DIRECTIONS	START/END DATE	DISC. REASON

PRESCRIPTION INFORMATION

MEDICATION NAME & DOSE	DIRECTIONS	QUANTITY	REFILLS

PRESCRIBER SIGNATURE (No electronic or digital signature)

I authorize Legacy Specialty Pharmacy and its representatives to serve as my authorized agent, including but not limited to, secure coverage and initiate the medical and prescription insurance prior authorization process for our shared patient.

DISPENSE AS WRITTEN	SUBSTITUTION PERMITTED
Prescriber Signature: _____ Date: _____	Prescriber Signature: _____ Date: _____