MEMORIAL HERMANN Specialty Pharmacy

REFERRAL FORM

Prescriber, please sign and fax completed form to 713.704.3841
For questions, please call 281.698.6100

SHIP TO: ☐ Patient ☐ Office (1st dose) ☐ Office (All doses)

Patient Information

Please include copy of prescription and medical insurance card, front and back

Patient Name: _____ Date of Birth: _____

Street Address: _____ Phone: _____

City, State, Zip: _____ Allergies: _____

Prescriber Information

Prescriber Name: _____ NPI: _____

Specialty: _____ Phone: _____

Office Street Address: _____ Fax: _____

City, State, Zip: _____ Office Contact: _____

Patient Medical Information

**Please include copies of any pertinent clinical notes and lab work **

Diagnosis (ICD-10): Primary ICD-10: _____ Description: _____ Diagnosis Date: _____

Other ICD-10 (if applicable): _____ Description: _____ Diagnosis Date: _____

Previous and/or Current Medications Used to Treat this Diagnosis:

Medication Name(s)	Current Use	Start Date	End Date	Discontinue Reason (if stopped)
	☐			☐ Failed ☐ Other Explanation:_____
	☐			☐ Failed ☐ Other Explanation:_____
	☐			☐ Failed ☐ Other Explanation:_____
	☐			☐ Failed ☐ Other Explanation:_____

Prescription Information

Medication Name / Strength / Dosage Form	Directions	Original Quantity	Refills

Prescriber Signature (No Stamps Permitted)

By signing below, I authorize Memorial Hermann Specialty Pharmacy to serve as my designated agent, if needed, to initiate and execute any applicable authorization processes with medical and prescription insurance companies. To prohibit generic substitution write "brand necessary" or "brand medically necessary" on the face of the prescription in your own handwriting.

Prescriber's Signature : _____ Date: _____