QUANTITY REQUEST FAX FORM

FAX: 1-800-956-2397

Please complete all of the following Patient/Physician Information:

Patient Name: (Please Print)	
FLRx Patient ID number:	**Patient Birthdate:**
MD Name:	**MD Specialty:**
MD Phone #: ( )	**MD FAX #: ( )**
MD DEA #:	**MD NPI #:**

1. Drug Request:

Drug Name	Strength	Quantity	Directions for use	Duration of therapy

2. Primary Diagnosis: _____

3. Current drug regimen:

Drug: _____ **Strength** _____ **Freq.** _____ **Period of use** _____ ***to*** _____

4. Previous therapies attempted:

Drug: _____ **Strength** _____ **Freq.** _____ **Period of use** _____ ***to*** _____

Drug: _____ **Strength** _____ **Freq.** _____ **Period of use** _____ ***to*** _____

5. Justification for dosage being requested:

_____

_____

_____

_____

PLEASE SUBMIT RECENT PROGRESS NOTES RELATING TO ABOVE DIAGNOSIS

I certify that the above information is true and accurate to the best of my knowledge. **To avoid processing delays, please add your electronic signature below or print this document and provide your handwritten signature.**

Provider Signature: _____ **Date** _____

If preferred, a letter of medical necessity may be attached to this form and submitted with the appropriate patient information.

Return completed form by Fax or Mail:

FAX: 1-800-956-2397

MAIL: FLRx Pharmacy Help Desk, 165 Court St, Rochester, NY 14647

Urgent Requests Only: 1-800-208-4050 (fax) 03/08