





CareMed


Pharmaceutical Services


Phone: 516.355.2273 Fax: 516.326.2273


HemaCare Prescription Form

NeuroCare 

ImmunoCare 

OncoCare 

RheumaCare 

HepaCare 

Patient Information

Last Name	First Name	SSN	DOB
Home Address	City	State	Zip
Home Phone	Work Phone	Parent/Guardian	
Shipping Address	City	State	Zip
Other Pertinent Information			

Delivery Information

Today's Date:	Date & Time Needed:	Deliver to:
		<input type="checkbox"/> Patient's Home <input type="checkbox"/> MD Office/Clinic <input type="checkbox"/> Patient's Work <input type="checkbox"/> Other: _____

Pharmacy Insurance Information

Primary Insurance:	Rx Bin:
ID Number:	Group Number:
Secondary Insurance:	Rx Bin:
ID Number:	Group Number:

Medications (You may tape Prescription here prior to faxing)

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Procrit®				
<input type="checkbox"/> Aranesp®				
<input type="checkbox"/> Neupogen®				
<input type="checkbox"/> Neulasta®				
<input type="checkbox"/> Neumega®				
<input type="checkbox"/> Lovenox®				
<input type="checkbox"/> Innohep® (CareMed Prefilled Syringes)				
<input type="checkbox"/> Arixtra®				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Physician Information

Prescriber Name:	DEA:		
Licence:	Office Contact:		
Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Diagnoses Information

Primary Dx	ICD-9
Secondary Dx	ICD-9
Tertiary Dx	ICD-9

Special Instructions/Information

Patient Clinical Information

Weight:	Height:	INR:	ANC:	Date of labs:

PRESCRIBER'S SIGNATURE REQUIRED

MD / NP / PA Signature: _____
