

10 mg/mL

LIQREV® PRESCRIPTION REQUEST FORM DIRECT TO SPECIALTY PHARMACY

CVS Specialty Fax: 877-943-1000 Tel: 877-242-2738

Please complete and fax to the specialty pharmacy of your choice:

Optum Specialty Pharmacy Fax: 877-342-4596 Tel: 855-427-4682

Accredo Health Group, Inc. Fax: 888-686-1035 Tel: 866-344-4874

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	PATIENT I	NFORI	MATION				PR	ESCRIBE	ER INFORM	NOITAN
First Name:		Last Nan	ne:		M.I.	Pres	scriber First Name	e:	Last Name:	
Gender:	DOB: (dd/mm/yy	yy) Prefe	erred Langu	age:		Pres	scriber Specialty:			
Male Female										
Street Address:		•				Pra	ctice Name:			
City:			State:	ZIP:		Pres	scriber Email:			
						1100	JOHN EIHAM.			
Home Phone:						Stro	et Address:			
						Sile	et Address.			
Cell Phone:						City				State: ZIF
						City	<u>. </u>			State: ZIF
Email:						011			000 5	
						Offic	ce Phone:		Office Fa	ax:
Authorized Caregive	er or Alternate	Contact:								
						MD	NPI #:	Tax ID:		State Li
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						Offi	ce Contact Name	:		
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Policy Holder Name	٥٠.					Dire	ctions for Use:			
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	SCRIBER	INFUR	INAIN			
Prescriber First Name:	Las	st Name	:			M.I.
Prescriber Specialty:						
Practice Name:						
ractice Name.						
December 5 and 1						
Prescriber Email:						
Street Address:						
City:			State:	ZIP	:	
Office Phone:		Office	Fax:			
MD NPI #:	Tax ID:		St	ate Lic	cense #:	
Office Contact Name:						
Office Contact Phone:						
Office Contact Email:						
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	DIAG	NOSIS				
Patient Diagnosis (ICD	-10):					
PRESCRIPTION	N INFORM <i>i</i>	ATION	& AUT	HOF	RIZATIO	ON
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