Whole Health Pharmacy

Prescription Request Form

Fax: 949-340-8008
Phone: 949-305-0788
1415 N Broadway, Santa Ana, CA 92706

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name ______	Prescriber Name ______
Address ______	DEA ______
Address 2 ______	NPI ______
City, State, Zip ______	Address ______
Home Phone ______ Mobile Phone ______	City, State, Zip ______
DOB ______ Gender ______	Phone ______ Fax ______
	Contact Person ______

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Duexis Tablet** (Ibuprofen 800mg/Famotidine 26.6mg) - Take 1 tablet by mouth 3 times a day			☐90 Tablets	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐11 ☐ ______
☐ **Pennsaid 2% –** Apply 2 pumps to the affected area twice a day			☐112 Grams	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐11 ☐ ______
☐ **Rayos 5mg Tablet –** Take ____ tablet(s) by mouth at bedtime with food			☐30 Tablets ☐60 Tablets ☐90 Tablets ☐____ Tablets	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐11 ☐ ______
☐ **Rayos 2mg Tablet –** Take ____ tablet(s) by mouth at bedtime with food			☐30 Tablets ☐60 Tablets ☐90 Tablets ☐____ Tablets	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐11 ☐ ______
☐ **Rayos 1mg Tablet –** Take ____ tablet(s) by mouth at bedtime with food			☐30 Tablets ☐60 Tablets ☐90 Tablets ☐____ Tablets	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐11 ☐ ______
☐ **Vimovo Tablet**	☐Naproxen 375mg/Esomeprazole 20mg – Take 1 TAB PO BID ☐Naproxen 500mg/Esomeprazole 20mg – Take 1 TAB PO BID		☐30 Tablets	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐11 ☐ ______
☐ **Other**				☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐11 ☐ ______

Ship to: ☐ Patient ☐ Office ☐ Other ______ Date: ______ Need by Date ______

**Prescriber Authorization:* I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature: ______ Date: ______

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