Prescription Form

Fax to: 1-888-660-0124

Prescriber Information

Prescriber Name ______________________ Title __________ NPI# ________ Tax ID# ________

Facility Name / Address ______________________ City __________ State ______ Zip ________

Office Contact Name ______________________ Office Contact Email ______________________

Phone (_____) ______ - ________ Fax (_____) ______-________ Supervising Physician ______________________

Clinical Information for Insurance Prior Authorization (Please include a copy of the patient's clinical notes, if Available.)

Diagnosis:

Chronic Sinusitis:

- ❑ J32.0 Chronic maxillary sinusitis
- ❑ J32.1 Chronic frontal sinusitis
- ❑ J32.2 Chronic ethmoidal sinusitis
- ❑ J32.3 Chronic sphenoidal sinusitis
- ❑ J32.4 Chronic pansinusitis
- ❑ J32.8 Other chronic sinusitis
- ❑ J32.9 Chronic sinusitis, unspecified

Nasal Polyps:

- ❑ J33.0 Polyp of nasal cavity
- ❑ J33.1 Polypoid sinus degeneration
- ❑ J33.8 Other polyp of sinus
- ❑ J33.9 Nasal polyps, unspecified
- ❑ Other Dx code(s) ______________________

Most Recent Steroid Treatment:

❑ Flonase ❑ Dymista ❑ QNASL ❑ Nasonex ❑ Nasacort ❑ Rhinocort ❑ Other ____________

Approximate start and end dates of most recent treatment ______________________

Surgical history ______________________

Drug allergies ______________________

Prescription

- ❑ 1 spray per nostril twice daily: Dispense 1 unit
- ❑ 2 sprays per nostril twice daily: Dispense 2 unit

REFILLS: 1 2 3 4 5 6 12

Prescriber Authorization (Required)

I authorize the designated pharmacy to act as an agent to initiate and execute the insurance prior authorization process, if necessary, for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice.

Prescriber's Signature ______________________ / ______________________ Date _____ / _____ / ________

(Substitutions Permitted) (Dispense as Written)

Patient Information

Patient Name ______________________ DOB ____ / ____ / ____ Sex ❑ M ❑ F

Street Address ______________________ City __________ State ______ Zip ________

Mobile Phone (_____) ______ - ______ Home Phone (_____) ______-________ Email ______________________

Patient Insurance Information

Prescription Plan Name ______________________ Group # ______________

Policy # ______________________ Rx BIN # ______________ Rx PCN ______________

Insurance Phone (_____) ______ - ______ Policyholder Name ______________________ DOB ____ / ____ / ____

Additional Clinical Notes: ______________________

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PLEASE COMPLETE AND SIGN FORM. FAX COMPLETED FORM TO ASPN PHARMACIES, LLC 1-888-660-0124

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Please see Indication, Important Safety Information and full Prescribing Information

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