Rosh Pharmacy- Topical Medication Order Form

NPI: 13 16481880

PATIENT NAME		DOB	
Address			
Phone Number		Allergies	

Please complete this form and fax WITHIN 24 HOURS to fax number: (832) 939-3560. You may also call the pharmacy directly to approve the prescription verbally to (832) 939-3550.

DOCTOR NAME		NPI:	
Address			
Phone		Fax	

_____Lidocaine 5% Ointment Quantity: 200 Grams

Sig: Apply 2—4 grams to the 3-4 times daily as needed Refills: _____
for pain. (Max 5 grams in 24 hours).

ICD-10 Diagnosis code: ☐ E10.41 ☐ E10.42 ☐ E11.41 ☐ E11.42

E10.41-Type 1 diabetes mellitus with diabetic mononeuropathy

E10.42-Type 1 diabetes mellitus with diabetic polyneuropathy

E11.41- Type 2 diabetes mellitus with diabetic mononeuropathy

E11.42- Type 2 diabetes mellitus with diabetic polyneuropathy

The above information is true, accurate and complete to the best of my knowledge. I confirm that the patient has the diagnosed condition is/was being treated by me and is able to use the ordered items. The medical records for this patient substantiate the prescribed medication. The patient or caregiver is able to follow instructions and is able to use the ordered items. Per Medicare/Insurance requirements, I will maintain a copy of this order in the patient's medical record. I agree to provide copies of supporting medical records as requested for insurance review. Provider also agrees that the rights of the patient to freedom of choice have been upheld

Physician's Signature _____ Date _____

Physician Name (Printed): _____ NPI: _____

Physician Assistant Name (If applicable): _____