Medication Order Form

Patient Name		DOB	
Address			
Phone Number		**Allergies**	

Doctor Name		**NPI:**	
Address			
Phone		**Fax**	

Please fill sections 1 and 2 and FAX the order form to the pharmacy at **832-939-3560** or contact the pharmacy at **832-939-3550** to approve it over the phone.

Disclaimer: Rosh Pharmacy will supply medications in regard to the following disease states: ***hypertension, hyperlipidemia, and diabetes.***

1) MEDICATION(S) ORDERED:

Medication	Quantity	Direction	ICD-10	Refills Authorized
VASCEPA 1 GM CAPSULES	90 DAYS SUPPLY	2 CAPS PO BID		

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

2) Physician's Signature _____ Date _____

Physician Name (Printed): _____

Physician Assistant/Nurse Practitioner Signature (If applicable):
_____