benevere PHARMACY

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beneverepharmacy.com

TODAY'S DATE: _____

☐ NEW PATIENT ☐ CURRENT PATIENT

Thyrogen Referral Form

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell _____
DOB _____ SSN _____
Drug Allergies _____ ☐ Male ☐
Patient Weight: _____ Height: _____

PRESCRIBER INFORMATION

Prescriber Name _____ Lic# _____
DEA# _____ NPI _____
Practice Name _____
Address _____ Suite _____
City _____ State _____ Zip _____
Office Phone _____ Fax _____
Office Contact _____

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance _____
Policy # _____ Group _____
Insurance Phone _____
Prescription Drug Coverage: Company _____
RXGRP# _____ RXBIN# _____ PCN/ID# *(if available)* _____

Secondary Insurance (if applicable) _____
Policy # _____
Insurance Phone _____
Phone _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS

CLINICAL INFORMATION

Primary Diagnosis: _____ ICD9: _____
Secondary Endocrine Diagnosis/Treatment: _____
History (check all that apply): ☐ Thyroid Cancer _____ ☐ Thyroidectomy Date: _____

DRUG NAME	DOSE/FREQUENCY	DIRECTIONS FOR USE	QTY	REFILLS
☐ Thyrogen®	1.1 mg vial	Inject 0.9mg intramuscularly daily for 2 days.		

☐ Patient has received injection training ☐ Physician's office to provide injection training ☐ Benevere Rx to coordinate injection

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

By signing this form and utilizing our services, you are authorizing Benevere and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

Please fax completed referral form to Benevere at 901.316.5760

visit us at www.beneverepharmacy.com for online fillable forms.