Specialty Pharmacy

Medi- Serv Pharmacy
2611 Webster Ave. Bronx NY 10458
718-395-4000

Send Prescriptions to Fax # (347) 233-3281

Patient Prescription Request Form

Name:________________________________ **D.O.B**____________ Sex:________

Address:__________________________ City:__________ State:______ Zip:________

Phone #:______________________ Health Insurance ID#:________________________

Patient Signature:____

☐ Pain Cream	☐ Flector Patches	☐ Pain Tablets
Lidocaine 5% Ketoprofren 20% Gabapentin 4% Menthol 3% Camphor 3% Diclofenac 3% CREAM BASE QID AD 240 GMS APPLY 4 PUMPS DAILY	#60 Patches Apply 2 times daily	Vimovo 375 OR 500 -20mg #60 TABS Take 1 Tablet by mouth twice daily as needed for pain

Prescriber Authorization

Refill amount: ☐ 3 refills ☐ 5 refills ☐ _____

➡ **Indicate in notes, Diagnosis/ICD-10 codes:** ____________________________

Physician Name: ________________________________ NPI#: ______________

Address: ______________________ City: ____________ State: ______ ZIP: ________

Phone#: ______________________ Fax#: ______________________________

➡ **Physician Signature:** ________________________________ **Date:** __________

Delivery will be included with your order. We specialize in obtaining Prior Authorizations.