Galaxy SPECIALTY PHARMACY
(Christus SantaRosa Hospital, Tower # 1)

Faxed prescriptions will only be accepted from a prescribing practitioner.
Patients must bring an original prescription to the pharmacy.

PRESCRIPTION REFERRAL FORM

2829 Babcock Road, Suite # 120 • San Antonio- 78229, TX • Ph : 210.617.4311 • Fax: 210.617.4312
www.GalaxySpecialtyPharmacy.com

Date Medication Needed: _____ **Deliver To:** ◯ Patient's Home ◯ Prescriber's Office ◯ Pickup (store location): _____ Injection training by pharmacy?

1: Patient Information

Patient Name: _____ **Birthdate:** _____ **Sex:** Male Female **Height:** _____ **Weight:** _____ ◯lbs. ◯ kg.

Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Alternate Caregiver Name: _____ **Preferred Phone:** _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name(s):

_____ **DEA#:** _____ **NPI#:** _____ _____ **DEA#:** _____ **NPI#:** _____

_____ **DEA#:** _____ **NPI#:** _____ _____ **DEA#:** _____ **NPI#:** _____

_____ **DEA#:** _____ **NPI#:** _____ _____ **DEA#:** _____ **NPI#:** _____

Practice Info:

Practice Name: _____ **Address:** _____

City _____ **State** _____ **ZIP** _____ **Tax ID#** _____

Phone: _____ **Fax:** _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: _____ **ICD-10:** _____

4: Prescription Information

Medication	Dose/Strength	Max. Daily Dosage	Sig	Qty.	Refills

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: Date:

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissable Date

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: _____