KERR HEALTH
Specialty Pharmacy

Prescription Referral Form

Phone (866) 443-1904 • Fax (877) 465-6091 • www.kerrhealth.com

TODAY'S DATE:	
DATE SHIPMENT NEEDED:	
❑ **NEW START** ❑ **CONTINUATION OF THERAPY**	
SHIP TO: ❑ PATIENT ❑ PHYSICIAN ❑ KERR DRUG STORE: _____	

GENERAL INFORMATION

PATIENT (FIRST NAME, LAST NAME):		ADDRESS:	
CITY:	STATE:	ZIP:	DOB:
SS#:	HOME#:	CELL#:	WORK#:
ALLERGIES:	❑ MALE ❑ FEMALE	HEIGHT:	WEIGHT:
CURRENT MEDS:			
PHYSICIAN NAME:		PRACTICE NAME/HOSPITAL:	
ADDRESS:	CITY:	STATE:	ZIP:
PHONE#:	FAX#:	STATE LIC#:	DEA#:
NURSE/KEY OFFICE CONTACT:		NPI#:	

INSURANCE INFORMATION

PRIMARY INSURANCE:		EMPLOYER:	
CARDHOLDER NAME:	ID#:	GROUP#:	PHONE#:
SECONDARY INSURANCE:	ID#:	GROUP#:	PHONE#:

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS:	ICD 9 CODE:

ADDITIONAL INFORMATION:

PRESCRIPTION INFORMATION

Rx

Please enter or affix prescription here or attach as additional page(s) to fax

* If you would like brand name, please write "**Brand Medically Necessary**". Please note that Kerr Health Specialty Pharmacy will dispense our formulary product unless otherwise specified. _____

I authorize Kerr Health Specialty Pharmacy and its representatives to act as my agent for prior authorization and prescription processing for this patient.

Physician Signature: _____ Date: _____

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