

START SENDING SCRIPTS TO



STEP 1: Fill out the top portion.

Have the patient's demographic sheet and Rx Insurance Card available.

Patient Information:		PLEASE FAX with Patient Demographic Sheet & Rx Insurance Card	
REQUIRED	FIRST NAME: <i>JANE</i>	LAST NAME: <i>DOE</i>	Additional Info
	PRIMARY PH #: <i>(313) 555-1234</i>	SECOND PH #: <i>(248) 123-5555</i>	
	DATE OF BIRTH: <i>03/18/64</i>	<input type="checkbox"/> Check here if this is a Worker's Comp or Auto Claim prescription.	
	ALLERGIES: <i>none known</i>		
	ADDRESS: <i>1234 CHERRY LANE</i>		
	CITY, STATE, ZIP: <i>DETROIT, MI 48235</i>		
	EMAIL ADDRESS: <i>jane@doe.com</i>		
	LAST 4 DIGITS OF SSN: <i>3456</i>		

STEP 2: Check the meds you wish to prescribe, or write your own in the blank space provided. Include quantity and refills.

<input checked="" type="checkbox"/>	# 5. Formula
Diclofenac sodium 3%	
Gabapentin 6%	
Lidocaine 2%	
Prilocaine HCl 2%	
Refill: <i>2</i>	
QTY (gm):	<input checked="" type="checkbox"/> 240 <input type="checkbox"/> Other
SIG: Apply 1-2gm topically to affected area TID-QID	

STEP 3: Sign and date the bottom portion.

Prescriber Information:	Contact Information:
PREScriBER'S SIGNATURE: <i>[Signature]</i>	ADDRESS: <i>1234 MAIN STREET, SUITE 23</i>
PREScriBER NAME (PRINT): <i>JOHN SMITH, MD</i>	CITY: <i>DETROIT</i>
NPI# or DEA# (CTP# for CNPs only): <i>782347382</i>	STATE: <i>MI</i>
DATE: <i>09/04/13</i>	ZIP: <i>48017</i>
	PHONE #: <i>313-555-5555</i>
	FAX #: <i>248-555-5555</i>

STEP 4: Fax directly to our pharmacy!

With demographic sheet and Rx Insurance Card.

A Service Liaison can program BioMed Formulations into your EMR upon request.

BioMed will provide:

- Free & Reliable Delivery or Shipping to the patient's home
- Education and Counseling on medications and treatment

Fax: 877. 791. 7779

Ph: 855. 246. 6338

23815 Northwestern Hwy.
Southfield, MI 48075



www.biomedpharmacy.com
www.targetedpaincontrol.com