GENERAL Referral Form

Perigon PHARMACY THREE SIXTY

1120 Stevenon Mill Rd. Suite
200 Coraopolis, PA 15108

Main: (412) 684-2500

Fax: (844) 528-5332

NCPDP: 6004117 NPI: 1669823266

Fax to: (844) 528-5332

Faxed prescriptions will only be accepted from a prescribing practitioner.
Patients must bring an original prescription to the pharmacy.
Prescribers are reminded patients may choose any pharmacy of their choice.

Please contact your Perigon Pharmacy Three Sixty team if you have any questions and/or concerns at (412) 684-2500

Date Medication Needed: _____

Ship To: Patient's Home / Prescriber's Office

1 Patient Information

Patient Name: _____ DOB: _____

Soc. Sec. #: _____ Email: _____

Home Phone: _____ Mobile Phone: _____

Preferred Phone: Home / Mobile (circle one)

Address: _____

City: _____ State: _____ ZIP: _____

Alternate Caregiver Information

Alternate Caregiver Name: _____ Phone: _____ Email: _____

2 Prescriber Information

Provider Name: _____ NPI#: _____

Practice Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Tax ID#: _____

Phone: _____ Fax: _____

Practice Contact Information

Practice Contact: _____

Contact Phone: _____ Contact Email: _____

3 Clinical / Diagnosis Information

PLEASE FAX *(1) Therapy regimen(s) / schedule, (2) last clinical notes and (3) lab values/scans -- (current and past)*

Sex: Male Female Height: _____ Weight: _____ lbs. kg. (circle one)

Diagnosis: _____

ICD-10: *(required for Medicare B billing)* _____

Previously Tried Therapy: _____

Reason for D/C: _____

Other Information: _____

Known Allergies

Allergy: _____

Severity: _____ Rescue Medication? Yes / No (circle one)

4 Insurance Information

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

5 Prescription Information

STRENGTH / DIRECTIONS (SIG):	Qty:	Refills:
1		
2		
3		
4		

Prescriber Signature: Prescriber, please sign and date below

PHYSICIAN SIGNATURE REQUIRED

Dispense as written | Date | Substitution Permissible | Date

I authorize Perigon Pharmacy Three Sixty and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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: _____