Maxor® SPECIALTY PHARMACY

PRESCRIPTION ORDER FORM

Phone: 800-818-6486

Fax: 800-818-6490

Patient: _____ DOB: _____ Gender: _____

Allergies: _____

Caregiver Name: _____ Primary Contact Number: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____ Relationship: _____

Please Attach a Copy of Insurance Card(s) (Front & Back)

Rx (Drug Name): Hemangeol 4.28mg/ml 120mL bottle

Diagnosis Code: _____

Directions:

_____

_____

_____

Patient's Weight (kg) and date taken _____

Number of 120mL bottles ◯ 1 ◯ 2 ◯ 3 ◯ 4

Refills _____

Prescribing Physician Information:

Physician Name: _____ Physician Specialty: _____

Practice/Facility Name: _____

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

Contact Person: _____ Phone: _____ Fax: _____

Contact Email: _____ DEA #: _____ NPI #: _____

PRESCRIBER SIGNATURE: _____ **DATE:** _____

(Dispense as Written)