Faxed prescriptions will only be accepted from an authorized prescriber. Prescribers are reminded patients may choose any pharmacy of their choice.

Sage Specialty Pharmacy General Prescription Form

WWW.SAGE-SPECIALTYPHARMACY.COM

Patient Information: please provide a copy of the patient's insurance card or information

Patient Name:	DOB:	Gender: ☐ F ☐ M	HT:	WT:
Address:	City:	State:	Zip Code:	Phone:
Insurance:	Subscriber's name:	ID#:	Group #:	
Allergies: ☐ NKDA ☐ List allergies:				

Clinical Information: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization

Diagnosis / ICD-10:

Prior Therapies:

Prescription Information

Medication	Dose / Strength	Directions	Quantity	Refills

Physician Information

Prescriber name:	Phone:	Office contact name:	
Prescriber address:	City:	State:	Zip:
NPI:	DEA:	Fax and/or Email:	
Prescriber signature:	Date:	☐ DO NOT SUBSTITUTE	

I authorize Sage Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.