XUBEX®
Specialty Pharmacy Services
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Patient Intake Form-GENERAL

3796 Howell Branch Road • Winter Park, FL 32792
Toll free: 866-699-8239 • Toll free fax 866-495-3304

TODAY'S DATE_____ DATE NEEDED_____

PATIENT INFORMATION			
First:	Last:	M.I.:	
Date of Birth:	SSN:	☐Male ☐ Female	
Best Phone:	Alt. Phone:	Email:	
Address:	City:	State:	Zip:

PRESCRIBER INFORMATION			
First:	Last:	M.I.:	
DEA#:	Med. Lic. #:	NPI#:	
Office Contact:	Phone:	Alt. Phone:	
Address:	City:	State:	Zip:

INSURANCE INFORMATION (PLEASE FAX COPIES OF FRONT AND BACK OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS)					
Primary:	PCN:	BIN#	**Secondary:**	PCN:	ID#:
Phone:	ID#:	Group#	Phone:	BIN#	Group#
Prescription Drug Insurer:	Phone:	RxGrp#:		RxBIN#:	PCN/ID#:

CLINIC INFORMATION			
Diagnosis:	ICD-9:	Diagnosis Date:	
Lab Values: WBC_____ ANC_____ Hgb_____ Hct_____ Plate_____ BSA_____		Height:	Weight:
Medical Justification (Failed Medications, Allergies, etc.):			
Current Therapies/Medications including OTC:			
Will patient stop taking the above medications before starting the new medication? ☐ Yes ☐ No	If yes, what is the washout period?		

☑ **PRESCRIPTION (PLEASE SELECT FROM THE BELOW AND PROVIDE APPROXIMATE DAYS SUPPLY)**

DRUG NAME	PRESCRIPTION ORDERS	QUANTITY	REFILLS

ADDITIONAL INSTRUCTIONS	
Please Deliver To: ☐ Patient's Home ☐ Dr.'s Office ☐ 1st dose to MD's office, remaining refills to patient's home	
Physician's Signature:	Date: