New Prescription Fax Form

Fax to (855) 494-1548

Patient Name _____ DOB _____ Sex M / F

Cell Phone _____ Delivery Address _____

_____

Prescriptions

Medication	Strength	QTY	Directions	Form (cap, tab, etc.)	Refills
Trudhesa	0.725 MG /ACT (1.45mg/ dose)	4	Use 1 spray in each nostril as needed at the onset of migraine. May repeat in 1 hour. Maximum 2 doses per day. Maximum 3 doses per 7 days.	NS (Nasal Spray)	

DAW

ICD-10 _____

Past Tried/Failed Meds _____

Provider Signature _____ Date _____

Provider Information

Provider's Name _____ DEA _____ NPI _____

Office Address 1151 Old York Road, Suite 200 City Abington

State & ZIP PA 19001 Office Phone 215-957-9250 Fax 215-957-9254

eRx: Phil AZ

6991 E. Camelback Rd., Suite 340-C, Scottsdale, AZ 85251/ Ph: (855) 588-0387 Fax: (855) 494-1548