SPRIX® DIRECT

Cardinal Health Specialty Pharmacy
7172 Columbia Gateway Dr Columbia, MD 21046
PH: 1.844.97.SPRIX or 1.844.977.7749
Fax: 1.844.794.7275

Patient Information			
First Name:	Last Name:		Gender: ❑ M ❑ F
Date of Birth:	Email:		
Best Contact Number: ( ) (circle) Home/Work/Cell	Alternate Number: ( ) (circle) Home/Work/Cell		
Patient Home Address:			
City:	State:	Zip:	

Patient Insurance Information	
Pharmacy Insurance Name:	
Policy #:	Group #/RxGRP:
RxBIN:	RxPCN:

Prescription for SPRIX®

(Check all that apply) ❑ **1 Box (5 Single-Day Nasal Spray Bottles)** **# of Refills: _____**

❑ Check box to have it sent to the office- Patient will be provided counseling and the medication at the office

Directions: 1 spray in (❑**one** / ❑**both**) nostril(s) Q6-8 hours; Maximum daily dose is 4 doses.

Special Instructions: _____

Patient Weight(lbs): _____ Allergies: _____

Diagnosis/ICD Code: _____ Prior Therapies: _____

Prescriber Information		
Prescriber Full Name:		
(check): ❑ MD ❑ NP ❑ PA ❑ DO	NPI#	
Prescriber Office Address:		
City:	State:	Zip Code:
Nurse/Office Contact:	Office Ph: ( )	Fax: ( )

Prescriber signature: _____ **Date:** _____

Dispense as written – For brand SPRIX only

****Stamped signatures cannot be accepted. Please attach all prescriptions on Official State Prescription form IF mandated by individual state laws****

If you would like a confirmation of this prescription being received at the pharmacy, please circle the preferred method of contact: **Fax** or **Office Phone**

eScribe: Select Cardinal Health Specialty Pharmacy (NPI:1528398674) in your escribe system and send electronically. If you need help locating Cardinal Health Specialty Pharmacy, please contact your system administrator

Patient Authorization: By signing below, I authorize Cardinal Health Specialty Pharmacy (CHSP) to process the prescribed drug through my active insurance and ship to my home address or to my prescriber's office address (if requested by my prescriber) as designated on this form. I certify that the information contained herein is true, complete, and accurate.

Offer to counsel (counseling will be provided by the pharmacist if not checked)

❑ I decline the offer of counseling by the pharmacist on this prescription. If I have questions concerning this prescription, I am aware that a pharmacist is available to answer these questions at 1.844.97SPRIX (1.844.977.7749)

Patient Signature: _____ Date: _____

Terms and Conditions: Patients must have a valid prescription for SPRIX® 5 Single-Day Nasal Spray Bottles. Both, the prescriber and patient acknowledge that the program is for the brand name SPRIX® and elect to receive SPRIX® 5 Single-Day Nasal Spray Bottles and no generic substitution will be made (if applicable).

For prescribing office: Product received on behalf of the above patient is reserved for use only by that patient, and not eligible for resale. Must be refrigerated upon receipt and before use.