Walmart

General Referral Form

Phone: 1.877.453.4566 Fax: 1.866.537.0877 Email: Specialty@walmart.com

1. Patient information:

Patient's name: ______

DOB: ______ ☐ Male ☐ Female Street address: ______ City: ______
State: ______ State: ______ Home phone: ______ Cell phone: ______
Email: ______ Patient's primary language: ______ Weight (lb/kg): ______
Height (in/cm): ______ Allergies: ______
Primary insurance co: ______ Phone: ______ Policy # ______
Group#: ______ Secondary insurance co: ______ Phone: ______ Policy#: ______
Group#: ______ **(please attach copy of patient insurance cards)** Guardian/Caregiver (if applicable): ______

2. Prescriber information:

Prescriber's name/Title: ______

Phone: ______ Fax: ______ Office contact/Faxed by: ______
Email: ______ NPI/DEA #: ______ Deliver to: ☐ Office ◉ Patient
Prescriber address: ______ Date: ______
Prescriber signature: ______

Prescriber must manually sign. This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.

3. Prescriber information:

Please prescribe all necessary Loading/Maintenance/Concomitant/Premedication orders as well.

To prevent generic substitution, Prescriber to handwrite "Brand medically necessary" and sign here: ______

Medication	Strength/Formulation:	Directions:	Quantity/Refills:
☐ ______	☐ ______	☐ ______	☐ QTY: ______ ☐ Refills: ______
☐ ______	☐ ______	☐ ______	☐ QTY: ______ ☐ Refills: ______
☐ ______	☐ ______	☐ ______	☐ QTY: ______ ☐ Refills: ______
☐ ______	☐ ______	☐ ______	☐ QTY: ______ ☐ Refills: ______
☐ ______	☐ ______	☐ ______	☐ QTY: ______ ☐ Refills: ______
☐ ______	☐ ______	☐ ______	☐ QTY: ______ ☐ Refills: ______
☐ ______	☐ ______	☐ ______	☐ QTY: ______ ☐ Refills: ______

4. Clinical information:

☐ ICD 10 code: ______ Description: ______

☐ New to therapy ☐ Currently on therapy
☐ Loading dose needed? ☐ Strength of last dose: ______ ☐ Date of last dose: ______
☐ Samples provided ☐ Injection training provided by physician ☐ Yes ☐ No

Concurrent medications: ______
Previous therapies: ______ Other: ______

*****Please send all available chart notes, labs and medication Lists*****

5. Complete the following information if Walmart SPEC is to supply any ancillary supplies:

☐ Supplies such as needles, syringes, sterile water, etc. as needed for administration: Syringe 1mL

☐ Needle 18g 1.5" ☐ Syringe 3mL ☐ Syringe 10ml ☐ Needle 18g 1" ☐ QS: ______
☐ Needle 25g 1.5" ☐ Needle 22g 1.5" ☐ Needle 25g 5/8" ☐ Needle 25g 1" ☐ PRN refills: ______
☐ 32Gx4mm Pen Needle ☐ Needle 27g 0.5" ☐ Syringe ______ ml
☐ 32Gx4mm Pen Needle ☐ 31Gx5mm Pen Needle ☐ 31Gx8mm Pen Needle ☐ Alcohol pads: ☐ Sharps Container:
☐ Other: ______
☐ QS: ______ ☐ PRN refills: