

Prescription Order Form

Fax: (855) 494-1548

Toll free: (855) 588-0387

PATIENT INFORMATION

Name _____ Date of Birth _____

Street Address _____

City _____ State _____ ZIP _____

Best Daytime Phone _____ Mobile Phone _____

Diagnosis/ICD10 Code (Optional) _____

Past Tried/Failed Meds _____

Insurance Type ☐ Commercial Insurance ☐ Medicare ☐ Medicaid
☐ No Insurance (Cash) ☐ Other _____

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)	
Trudhesa [®]	0.725 MG/ACT (1.45mg/dose)	6	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)	

PRESCRIBER INFORMATION

Signature _____ Date _____

Name _____ DEA/NPI _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Phone Ext. _____ Fax _____

Office Contact _____ Email _____

PLEASE ATTACH COPY OF INSURANCE CARD (FRONT & BACK)

eRx: Phil AZ

14500 N. Northsight Blvd. Ste 314, Scottsdale, AZ 85260/ Ph: (855) 588-0387 Fax: (855) 494-1548