

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

REL26-01

PATIENT INFORMATION				
First Name	Last Name	Date of Birth ____ / ____ / ____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address		City	State	Zip
email	Home Phone		Cell Phone	

PRESCRIBER INFORMATION				
Prescriber Full Name			Prescriber Credential	
Office Address		City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone	
Practice Contact Person		Prescriber NPI	Preferred Contact Method <input type="checkbox"/> email <input type="checkbox"/> Phone <input type="checkbox"/> Fax	

CLINICAL INFORMATION – please include any relevant office visit/lab notes to support this prescription	
Patient is <input type="checkbox"/> Naïve <input type="checkbox"/> Previously Treated	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)	
Therapies Tried (please check name and include dates)	
<input type="checkbox"/> Acetaminophen	Date ____ / ____ / ____
<input type="checkbox"/> Topical NSAID(s) Please list name(s): _____	Date ____ / ____ / ____
<input type="checkbox"/> Oral NSAID(s) Please list name(s): _____	Date ____ / ____ / ____
<input type="checkbox"/> Physical and/or Occupational Therapy	Date ____ / ____ / ____
<input type="checkbox"/> Other:	Date ____ / ____ / ____
Current Medications (please list name and dose):	Reason(s) for Therapeutic Failure/Therapy Not Tried:
	<input type="checkbox"/> Previous adverse reaction(s)
	<input type="checkbox"/> Adherence concerns
	<input type="checkbox"/> Drug interaction(s)
	<input type="checkbox"/> Other (please list):
ICD-10 Code <input type="checkbox"/> M19.90 Osteoarthritis (unspecified)	
<input type="checkbox"/> M06.9 Rheumatoid Arthritis (unspecified)	
<input type="checkbox"/> Other: _____	

PRESCRIPTION – please check all boxes across row				
Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Relafen DS® (nabumetone oral tablet)	1000 mg tablet	<input type="checkbox"/> Take 1 tablet (1000 mg) by mouth as a single dose with or without food	<input type="checkbox"/> 30 Tablets	<input type="checkbox"/> 11
		<input type="checkbox"/> Take 1 tablet (1000 mg) by mouth twice daily with or without food	<input type="checkbox"/> 60 Tablets	<input type="checkbox"/> _____
			<input type="checkbox"/> _____	

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ MD DO PA CRNP **Date:** ____ / ____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

Note: The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.