SILENOR® (doxepin) Referral Form

PHONE: 888-412-9325 FAX: 877-329-9325 eRx NPI: 1093424905 www.zealsp.com

Zeal Specialty Pharmacy

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

SIL26-01

PATIENT INFORMATION

First Name	Last Name	Date of Birth ____ /____ / ____	Gender ☐ Male ☐ Female
Address	City	State	Zip
Email	Home Phone	Cell Phone	

PRESCRIBER INFORMATION

Prescriber Full Name		Prescriber Credential	
Practice Address	City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone
Practice Contact Person	Prescriber NPI	Preferred Contact Method ☐ Email ☐ Phone ☐ Fax	

CLINICAL INFORMATION – *please include any relevant office visit/lab notes to support this prescription*

Patient is ☐ Naïve / New Start ☐ Therapy Restart ☐ Existing Treatment

Therapy Start Date ____ /____ / ____

Allergies ☐ NKDA ☐ Drug Allergies (please list)

Therapies Tried and Failed (please check name and include dates)

☐ Zolpidem Date ____ /____ / ____
☐ Over the counter sleep aids (melatonin, diphenhydramine) Date ____ /____ / ____
☐ Cognitive behavioral therapy Date ____ /____ / ____
☐ Trazodone Date ____ /____ / ____
☐ Ramelteon Date ____ /____ / ____
☐ Other: Date ____ /____ / ____

Current Medications (please list name and dose)

☐ MAOI
☐ CNS depressants and sedating antihistamines
☐ Other: _____

ICD-10 Code: ☐ G47.0 Insomnia
☐ Other: _____

Indication Demographics:

☐ Face ☐ Scalp ☐ Both

Reason for therapeutic failure/therapy not tried

☐ Lack of efficacy in sleep latency, total sleep time, or nighttime awakenings
☐ Adverse reactions (daytime sedation, dizziness, orthostatic hypotension, anticholinergic effects)
☐ Interactions with current medication regimen
☐ History of substance use disorder
☐ Age (beers criteria)
☐ Adherence concerns

PRESCRIPTION – *please check all boxes across row*

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **SILENOR®** (doxepin)	☐ 3 mg tablet ☐ 6 mg tablet	Take 1 tablet by mouth once daily within 30 minutes of bedtime and ≥ 3 hours from a meal. Max daily dose is 6 mg.	☐ 30 tablets (1 bottle) ☐ _____	☐ 11 ☐ _____

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.*

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic	Date Shipment Needed By: ____ /____ / ____