



Today's Date: _____

Date Medication Needed: _____

MD Signature: _____ Date: _____

MD Name (Printed): _____ NPI: _____ DEA: _____

Phone: _____ Fax: _____ Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Fax completed form and all documentation to **844.246.3364**

All information contained in this form is strictly confidential and will become part of the patient's medical record.