LeMed
SPECIALTY PHARMACY

ALINIA

2417 3rd Ave, Ste 406
Bronx, NY 10451
Phone: 347-913-4656
Fax: 718-231-2727

Patient Information - Please send demographic sheet and a copy of the patient's insurance cards			
Patient Name:	Date of Birth:	☐ Male ☐ Female	
Address:	City:	State:	Zip:
Mobile Phone:	Home Phone:	Language:	
Allergies **(Required):** ☐ NKDA	Height: / Weight:	SSN:	
Medication Delivery Options: ☐ Patient's Home ☐ Hospital/Clinic Office ☐ Bedside **Delivery Address:**			

Prescriber Information			
Practice Name:	Office Contact:		
Prescriber:	NPI:	DEA:	
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information - Please send all available chart notes including lab results
ICD-10:
Therapies tried and failed with length of treatments:

Medication Name	Strength	Dose/Frequency	Duration
☐ Alinia (Nitazoxanide)	☐ 100 mg ☐ 200 mg ☐ 500 mg	Take 1 tablet by mouth every 12 hours	☐ Non-HIV Cryptosporidiosis x 3 days ☐ Giardiasis x 3 days
☐ Alinia (Nitazoxanide)	100 g/5 ml	☐ Take 5 ml (100 mg) by mouth every 12 hours ☐ Take 10 ml (200 mg) by mouth every 12 hours ☐ Take 25 ml (500 mg) by mouth every 12 hours	☐ Non-HIV Cryptosporidiosis x 3 days ☐ Giardiasis x 3 days
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The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize LeMed Specialty Pharmacy and/or its affiliate pharmacies to facilitate benefits investigations, complete and submit prior authorization (PA) requests, appeals, step edits and other processes necessary to obtain coverage for prescribed medications, to sign any necessary forms on my behalf of my patients, and to attach its Enrollment Form to the PA request as my signature.

***Fax does not constitute a valid prescription as per NYS Board of Pharmacy. Please electronically prescribe order.**

Prescriber Signature: _____ **Date:** _____