



Nitazoxanide Oral

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 | Quantity |
|-----------------------|-------------|--|----------|
| Nitazoxanide Oral | 500 mg | Take 1 tablet by mouth every 12 hours | |
| Alinia (Nitazoxanide) | 100 mg/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 | |
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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.

IMPORTANT NOTICE: This form is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

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

Prescriber Signature: _____ **Date:** _____