CureStat Rx
Home Infusion and Specialty Pharmacy

SAMCYPRONE
REFERRAL FORM

6725 MESA RIDGE RD. STE 230. SAN DIEGO, CA 92121
PHONE: (888) 963-6544 FAX: (858) 281-0045

PATIENT INFORMATION

PATIENT NAME:		PRIMARY PHONE:	
DOB:		ADDRESS:	
SSN:		CITY, STATE, ZIP:	
CAREGIVER NAME:		ALTERNATE PHONE:	

INSURANCE INFORMATION

(PLEASE FAX A COPY OF PATIENTS INSURANCE CARD INCLUDING BOTH SIDES)

PRIMARY INS:		SECONDARY INS:	
PLAN ID:		PLAN ID:	

PRIMARY DIAGNOSIS:

(PLEASE PROVIDE ICD-10 CODE)

☐ ☐

CLINICAL INFORMATION

GENDER: ☐ M ☐ F
WEIGHT: ☐ lbs ☐ kg
HEIGHT: ☐ In ☐ cm
IS THIS FIRST DOSE?: ☐ Yes ☐ No

DIAGNOSIS DATE:
COMORBIDITIES:
CONCOMITANT MEDICATIONS:
ALLERGIES: ☐ NKDA ☐ OTHER
ADDITIONAL COMMENTS:

PRIOR THERAPY

(PLEASE PROVIDE MEDICATION HISTORY)

PRIOR THERAPY ☐ YES ☐ NO	REASON FOR DISCONTINUATION OF THERAPY	START DATE	END DATE

REQUIRED DOCUMENTATION:

☐ INSURANCE CARD FRONT AND BACK ☐ MOST RECENT LABS ☐ H & P

DRUG	DOSE / STRENGTH	DIRECTIONS	QTY (5 Grams/tube)	REFILLS
☐ SAMCYPRONE (Diphenylcyclopropenone)	☐ 0.04% Ointment			
	☐ 0.4 % Ointment			

SHIP TO: ☐ PATIENT ☐ PRESCRIBER'S OFFICE NEEDS BY:

INJECTION TRAINING PROVIDED BY: ☐ PRESCRIBER'S OFFICE ☐ PHARMACY ☐ NA

PRODUCT SUBSTITUION PERMITED: ☐

DISPENSE AS WRITTEN: ☐

PRESCRIBER INFORMATION

PHYSICIAN NAME:		PHONE:		LICENSE #:	
OFFICE CONTACT:		FAX:		NPI #:	
ADDRESS:		CITY, STATE, ZIP:		DEA #:	

PRESCRIBER'S SIGNATURE:		**DATE:**	