



AQUORAL
Direct to Patient
Program

PHARMACY - ORDER FAX FORM
FAX TO: (866) 694-2555
CUSTOMER SERVICE #: (833) 821-8187

PATIENT INFORMATION

PLEASE INCLUDE COPY OF FRONT & BACK OF PHARMACY INSURANCE CARD

NAME: _____ DATE OF BIRTH: _____
PHONE #: _____ CELL PHONE #: _____ EMAIL: _____
ADDRESS: _____ APT/SUITE: _____
CITY _____ STATE: _____ ZIP CODE: _____
CURRENT MEDICATIONS TAKEN: _____
MEDICAL CONDITIONS: _____
ANY KNOWN ALLERGIES: _____

PRESCRIBER INFORMATION

NAME: _____
DEA #: _____ NPI #: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
PHONE #: _____ FAX #: _____
OFFICE CONTACT: _____ CONTACT PHONE #: _____
PHYSICIAN EMAIL: _____

PRESCRIPTION INFORMATION

AQUORAL (Artificial Saliva) Protective Spray 1 Box (2 x 10 ML Spray Bottles)

Directions: _____

Quantity _____ Refills _____

Prescriber Signature: _____ Date: _____

For **e-PRESCRIBING**, please use the following information for processing requests through your system:

Name: Transition Pharmacy **Pharmacy type:** Retail
City: Trevoise **State:** PA **Zip:** 19053
NPI #: 1336325265 **NCPDP #:** 3989603

There is no additional cost to the patient or physician for this service.