Patient Intake Form-MEDICAL WEIGHT-LOSS

XUBEX® Specialty Pharmacy Services
www.Xubex.com
3796 Howell Branch Road • Winter Park, FL 32792
Toll free: 866-699-8239 • Toll free fax 866-495-3304

TODAY'S DATE_____ DATE NEEDED_____

PATIENT INFORMATION				
First:	Last:	M.I.:	☐ Male ☐ Female	
Date of Birth:	SSN:		Best Phone:	
Address:	City:		State:	Zip:
Shipping Address (if different from home address):			Height:	Weight:

PRESCRIBER INFORMATION			
First:	Last:	M.I.:	
DEA#:	Med. Lic. #:	NPI#:	
Office Contact:	Phone:	Alt. Phone:	
Address:	City:	State:	Zip:

INSURANCE INFORMATION				
Name of Insured:	Insurance Company:	ID#:		
Phone:	BIN#	PCN:	Group#	

PLEASE FAX PATIENT'S FACE SHEET AND PHARMACY BENEFITS INFORMATION WITH PRESCRIPTION TO 866-495-3304

☑ MEDICAL WEIGHT-LOSS		
1	☐ Belviq	☐ 10mg Tabs
2	☐ Qysymia	☐ 3.75mg/23mg ☐7.5mg/46mg ☐ 11.25mg/69mg ☐ 15mg/92mg
3	☐ Phentermine	☐ 15mg ☐ 30mg
4	☐ Adipex	☐ 37.5mg ☐ Tabs or ☐ Caps
5	☐ Xenical	☐ 120mg
6	☐ Didrex	☐ 50mg
7	☐ Benzphetamine	☐ 50mg
8	☐ Diethylpropion	☐ 25mg or ☐ 75mg ER Tabs
9	☐ Phendimetrazine	☐ 35mg Tabs or ☐ 105mg Caps
10	☐ Cyanocobalamin (B12)	☐ 1000mg/mL
11	☐ Pyridoxine (B6)	☐ 100mg/mL
12	☐ Other	
13	☐ Other	

INSTRUCTIONS

Refills ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ AUTO | **Deliver To:** ☐ Patient's Home ☐ Prescriber's Office | ☐ Patient to pick up at Pharmacy

☑ **Medically Necessary**: I, the undersigned, certify that the above prescribed compounded medication is medically necessary as part of my treatment for this patient. In my opinion, the medication prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition.

Physician's Signature: Date:

FAX PRESCRIPTION TO: 866-495-3304

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