Liqrev®
(Sildenafil) Oral Suspension
10 mg/mL

LIQREV® PRESCRIPTION REQUEST FORM DIRECT TO SPECIALTY PHARMACY

Please complete and fax to the specialty pharmacy of your choice:

- ◯ **Accredo Health Group, Inc.** Fax: 888-686-1035 Tel: 866-344-4874
- ◯ **CVS Specialty** Fax: 877-943-1000 Tel: 877-242-2738
- ◯ **Optum Specialty Pharmacy** Fax: 877-342-4596 Tel: 855-427-4682
- ◯ **Other:** _____

PATIENT INFORMATION

First Name: | Last Name: | M.I.

Gender: ◯ Male ◯ Female | DOB: (dd/mm/yyyy) | Preferred Language:

Street Address:

City: | State: | ZIP:

Home Phone:

Cell Phone:

Email:

Authorized Caregiver or Alternate Contact:

Relationship to Patient:

Alternate Contact Phone:

Alternate Contact Email:

INSURANCE INFORMATION

◯ Patient has **NO** insurance

Fax a copy of front and back of patient's medical and prescription benefit insurance cards or please complete the information below.

Prescription Benefit Name: | Phone:

Member ID: | Group Number:

Policy Holder Name:

Policy Holder DOB: | Relationship to Patient:

Medical/Health Insurance Name: | Phone:

Member ID: | Group #: | PCN #: | BIN #:

Policy Holder Name:

Policy Holder DOB: | Relationship to Patient:

Secondary Benefit Insurance Name: | Phone:

Group Number:

Secondary Insurance Policy Holder Name:

Secondary Policy Holder DOB: | Relationship to Patient:

PRESCRIBER INFORMATION

Prescriber First Name: | Last Name: | M.I.

Prescriber Specialty:

Practice Name:

Prescriber Email:

Street Address:

City: | State: | ZIP:

Office Phone: | Office Fax:

MD NPI #: | Tax ID: | State License #:

Office Contact Name:

Office Contact Phone:

Office Contact Email:

DIAGNOSIS

Patient Diagnosis (ICD-10):

PRESCRIPTION INFORMATION & AUTHORIZATION

	Dose:	Quantity:	NDC #:	Refills:
◯ **Liqrev 10mg/mL**			**46287-055-01**	

Directions for Use:

I verify that the patient and healthcare provider information on this enrollment form was completed by me or at my direction and I have discussed with my patient and informed him/her of the Program enrollment. The information contained herein is complete and accurate to the best of my knowledge. I understand that I must comply with my practicing state's specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to me by the dispensing pharmacy.

By signing below I certify that I am prescribing the LIQREV medication for the patient identified in the Patient Information section. I certify that this prescription is medically necessary for the patient and that it will be used as directed. I certify that I will be supervising the patient's treatment and verify that the information provided is complete and accurate to the best of my knowledge.

Prescriber Signature: | Date:

Dispense as Written/Do Not Substitute

OR

Prescriber Signature: | Date:

Substitution Permitted