



Prescription Request Form

www.insulinoutlet.com
Phone: 1-888-238-0872
Fax: 1-888-804-1287
Email: info@insulinoutlet.com

Prescribers can fill out this form to send prescriptions directly to Insulin Outlet.
IMPORTANT: Prescriptions can only be accepted if they include the email address associated with the patient's user account.

Save time by requesting your own online portal! Free of charge!
Your office would be able to sign-in and upload prescriptions at ease!

Prefer to fax us the prescription?
Fax us at: **1-888-804-1287**

Date:

Patient Information

This fax is void unless prescribers return the form with mandatory fields completed

Last Name	<input type="text"/>	First Name	<input type="text"/>	MI	<input type="text"/>
Delivery Address	<input type="text"/>				
Apt., Ste. #	<input type="text"/>	Email Address	<input type="text"/>		
City	<input type="text"/>	State	<input type="text"/>	ZIP Code	<input type="text"/>
Phone Number (with area code)	<input type="text"/>				
Date of Birth (mm/dd/yy)	<input type="text"/>	Sex (assigned at birth)	<input type="radio"/> Female <input type="radio"/> Male		

Prescription Request

Medication	<input type="text"/>
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FOR PRESCRIBERS OFFICE

Prescription Information

Medication	<input type="text"/>	Strength mg., ml. etc	<input type="text"/>	Quantity	<input type="text"/>	Refills	<input type="text"/>
Directions Required	<input type="text"/>						
Medication	<input type="text"/>	Strength mg., ml. etc	<input type="text"/>	Quantity	<input type="text"/>	Refills	<input type="text"/>
Directions Required	<input type="text"/>						
Medication	<input type="text"/>	Strength mg., ml. etc	<input type="text"/>	Quantity	<input type="text"/>	Refills	<input type="text"/>
Directions Required	<input type="text"/>						
Medication	<input type="text"/>	Strength mg., ml. etc	<input type="text"/>	Quantity	<input type="text"/>	Refills	<input type="text"/>
Directions Required	<input type="text"/>						

Prescriber Information

Prescribing Physician Name	<input type="text"/>	Supervising Physician's Name (If applicable)	<input type="text"/>						
Physician Phone Number (with area code)	<input type="text"/>	Physician Fax Number (with area code)	<input type="text"/>						
Physician Street Address	<input type="text"/>		Unit #	<input type="text"/>					
City	<input type="text"/>	State	<input type="text"/>	ZIP Code	<input type="text"/>	NPI #	<input type="text"/>	DEA #	<input type="text"/>
Physician Signature <i>Your signature above indicates your approval of this prescription for the patient mentioned above</i>				Prescribing Date (mm/dd/yyyy)	<input type="text"/>				

CONFIDENTIALITY NOTE: Insulin Outlet has provided information in this document that is privileged, confidential, and/or may contain protected health information (PHI). According to applicable law, we are required to protect PHI. All information in this document is intended solely for the person(s) or company named above. PHI has been disclosed between these parties with the appropriate consent. The information contained in this document cannot be shared, copied, distributed or used without permission. In the event that the document(s) are not for you, please notify the sender and return them by email at info@insulinoutlet.com as soon as possible.