



ICORE Prescription Form

Today's date: ____/____/____

Patient name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Patient DOB ____/____/____ Please check one: New Patient Established patient Order change

Policy holder name: _____ Policy holder DOB ____/____/____

Ins ID / Group # _____ MD NPI# _____

M.D. name _____ MD LIC# _____

M.D. signature _____ MD DEA _____

Facility/Practice name _____

Phone _____

Address _____ City _____ State _____ Zip _____

Contact person _____ Phone _____

Primary ICD-9 Code _____

Diagnosis (in words) _____

Allergies NKA Other (list): _____

Medication	Strength/ Frequency	Qty	Date of Service	Medication	Strength/ Frequency	Qty	Date of Service	Medication	Strength/ Frequency	Qty	Date of service
Adriamycin				Procrit®				Risperdal®			
Adrucil®				Rituxan®				Romazicon®			
Aloxi				Taxotere®				Sandostatin LAR®			
Aranesp®				Vinblastine				Solu-Cortef®			
Atropine				Vincristine							
Avastin®											
Bleomycin				Mirena IUD				Amevive®			
Camptosar®				Other:				Carimune®			
Carboplatin				Other:				Cerezyme®			
Cisplatin				Ampicillin				Euflexxa®			
Dexamethasone				Bicillin				Gammagard®			
Dexferum				Botox®				Gamunex®			
Diphenhydramine				Ceftriaxone®				Hyalgan®			
Doxorubicin				Depo-Medrol®				Octagam®			
Eloxatin®				Gentamycin				Orthovisc®			
Erbitux®				Kenalog®				Remicade®			
Herceptin®				Ketorlac				Supartz®			
Infed				Lidocaine				Synvisc®			
Kytril®				Marcaine				Winrho®			
Leucorvin				Methylprednisolone				Other:			
Neulasta®				NABI-HB®				Other:			
Neupogen®				Naloxone				Other:			
Paclitaxel				Rhogam®				Other:			

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS THE PRESCRIBER WRITES IN THE BOX BELOW.

Dispense As Written