



Nuvail™

Sitavig®



Pharmacies LLC.

100 Campus Drive, Suite 300  
Florham Park, NJ 07932

# PRESCRIPTION FORM

**PLEASE COMPLETE FORM, SIGN, AND FAX TO 1-888-839-0055**

Date \_\_\_\_\_

Last 4 SS# XXX-XX- \_\_\_\_\_

DOB \_\_\_\_\_

Patient Name \_\_\_\_\_

**Patient Information**

Street Address (no PO box) \_\_\_\_\_

City	State	ZIP	Phone	Cell Phone
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Allergies \_\_\_\_\_

Other Medications \_\_\_\_\_

**Prescription Drug Insurance Card**

Plan Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Group Policy Number	Member ID
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Rx Bin Number	PCN Number
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Policyholder: Name/Relationship \_\_\_\_\_

**Prescriber Information**

Prescriber Name \_\_\_\_\_

Street Address \_\_\_\_\_

City	State	ZIP
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State License	NPI	DEA
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Office Contact Name \_\_\_\_\_

Office Phone Number	Office Fax Number
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**Prescription(s)**

**Bionect® (hyaluronic acid sodium salt, 0.2%)**     100g Cream    100g Gel    113g Foam    Quantity \_\_\_\_\_    Refills \_\_\_\_\_

Directions \_\_\_\_\_

NY Prescribers - Please submit prescription on an original NY State prescription blank.    TN Prescribers - Quantity must be written in both numerals and words. Example: 3 (three) doses.

Date \_\_\_\_\_    Prescriber's Signature \_\_\_\_\_

**Nuvail™ (poly-ureaurethane, 16%) Nail Solution**     15 mL bottle with applicator    Quantity \_\_\_\_\_    Refills \_\_\_\_\_

Directions \_\_\_\_\_

NY Prescribers - Please submit prescription on an original NY State prescription blank.    TN Prescribers - Quantity must be written in both numerals and words. Example: 3 (three) doses.

Date \_\_\_\_\_    Prescriber's Signature \_\_\_\_\_

**Sitavig® (acyclovir), 50mg Muco-Adhesive Buccal Tablet**     2 Blisters/1 tablet each    Quantity \_\_\_\_\_    Refills \_\_\_\_\_

Directions \_\_\_\_\_

NY Prescribers - Please submit prescription on an original NY State prescription blank.    TN Prescribers - Quantity must be written in both numerals and words. Example: 3 (three) doses.

Date \_\_\_\_\_    Prescriber's Signature \_\_\_\_\_

**FAX completed form to: 1-888-839-0055**