FAX: 844-524-HOPE (4673)
Phone: 844-690-4462

MEDICAL WEIGHT LOSS

3922B Willis Ave.
Louisville, KY 40207

Need By Date: / / SHIPTO: ☐ Office ☐ Patient ☐ Patient pick up in pharmacy

PATIENT INFO

Name:
Address:
City: State: Zip:
Phone: Alt. Phone:
Social Security#: DOB:
Height: Weight:
Alternate Contact: Phone:

PROVIDER INFO

Name: Dr. George Stege #500
Address: 2304 Hurstbourne Village Dr
City: Louisville State: KY Zip: 40299
Phone: 583-3191 Fax: 581-1463
NPI: 1548284425 DEA: AS9326340
License #: 20839
Contact Person: Brandi ph#: 583-3189

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

Diagnosis/Clinical information | Please FA recent clinical notes, Labs, Tests, with the prescription to expedite the Prior authorization

Diagnosis:

ICD-10: BMI: kg/m^2 Allergies:

Comorbidities present ☐ Hypertention ☐ Type II diabetes mellitus ☐ Dyslipidemia ☐ Other

Patient has tried / failed lifestyle modification? ☐ YES ☐ NO List Prior Failed Medications:

Medication	Dosage	Direction	QTY	Refills
☐ SAXENDA	3 mg / 0.5 mL multi-dose pen	☐ **INITIAL:** Inject 0.6 mg SQ once a day for 1 week, on week 2 inject 1.2 mg SQ once a day for 7 days, on week 3 inject 1.8 mg SQ once a day for 7 days, on week 4 inject 2.4 mg SQ once a day for 7 days then inject 3 mg SQ once a day thereafter. ☐ **MAINTENANCE:** Inject 3 mg SQ once a day	1	—
☐ Pen needles	32 gauge x 4mm	☐ Use are directed with Saxenda pens	120	—
☐ CONTRAVE	8 mg / 90 mg tablet ER	☐ **INITIAL:** One tablet once a day in the morning for 1 week; at week 2, increase to 1 tablet twice for 1 week; at week 3, increase to 2 tablets in the morning and 1 tablet in the evening and continue for 1 week; at week 4, increase to 2 tablets twice daily ☐ **MAINTENANCE:** Two tablets twice a day	120	—
☐ XENICAL	120 mg capsule	120 mg 3 times daily with each main meal containing fat	90	—

Prescriber Authorization: I authorize St. Matthew's Specialty Pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature________ Today's Date: / /

Patient Authorization: I authorize St. Matthews Specialty Pharmacy to bill my insurance company for this prescription and refills of this prescription. I understand that I am financially responsible for any co-pay/co-insurance amounts or other amounts not covered by my insurance. I understand that either I or my authorized representative will need to contact St. Matthew's Specialty Pharmacy if there are changes in my insurance or I no longer need this prescription
I allow my prescriber to be my authorized individual and may order my prescription refills / schedule delivery or pickup of my prescription
I understand I have an offer for prescription counseling by the pharmacist but decline the offer of counseling at this time.

Prescriber's Name________

Patient's Signature________

Important Notice: This fax is intended only to the named addressee and contains information that may be protected health information under federal and state laws. If you are not the intended recipient, do not copy, distribute, or disseminate. Please notify the sender immediately and destroy this document.
Revised 7/23/2020