Quickfill Pharmacy
18455 Burbank Blvd, Ste 105 Tarzana, CA 91356
Phone: 818-457-4011 Fax: 626-508-7799

Prescription Date:

A. PATIENT INFORMATION	B. PHYSICIAN INFORMATION
Patient Name: Address City: State: Phone: DOB:	Physician: Address: City: State: Phone: Fax: NPI:

Please complete steps 1 through 6 below, and sign.
PLEASE FAX BACK TO 1-626-508-7799

1. TESTING FREQUENCY
☐QD ☐BID ☐TID ☐QID ☐Other: _____x/day

2. ICD-10 DIAGNOSIS CODE: ☐E10 ☐E11 ☐E11.65 ☐Other: _____

3. SUPPLIES ORDERED: (Please strike out the items not prescribed)

Test Strips	Lancing Device
Blood Glucose	Alcohol Prep Pads
Control Solution	Lancets

QUANTITY: Send 90 Day supplies, unless otherwise directed by insurance

4. INSULIN TREATED? ☐YES ☐NO
Insulin Syringes: ☐YES ☐NO ☐QD ☐BID ☐TID ☐QID ☐Other: _____
Pen Needles: ☐YES ☐NO ☐QD ☐BID ☐TID ☐QID ☐Other: _____

5. LENGTH OF NEED: This order is good for one year from the signed date unless otherwise specified here: _____
REFILLS: 11 refills unless otherwise indicated here: _____

6. ALLERGIES: ☐ YES ☐ NO
IF YES LIST: _____

By signing, I certify (a) I am or was treating this patient on the effective date of this order: (b) This order accurately reflects this patient's diagnosis and condition and is substantiated by medical records. If prescribing a high-frequency regimen, I have seen this patients within the last 6 months to evaluate their medical condition: The patient or caregiver is (or) is scheduled to be trained in the use and administration of the above medications, and (d) I will make the original signed copy of this document a part of the patient's medical records and make it available to Medicare, Medicaid, and other insurers, that this pharmacy or any authorized agent, If requested.

Physician Signature: _____ Date: _____
Physician Name: _____ NPI: _____

PLEASE FAX TO: (626) 508-7799

Not Valid for Arizona Patient's