DIAMOND PHARMACY SERVICES

**STAT** (Standard) **STAT**

# *EMERGENCY PRESCRIPTION REQUEST*

**Fax completed request (verbal or signed) to the Diamond Backup Hotline: 1.866.307.9748**

Facility Name: _____ Date: _____ Time: _____ Rev. 8/16

Person Completing Form* _____

Phone: ( ) _____

*** I certify that the medications listed are on the formulary for my facility or has been approved.**

***SPECIAL INSTRUCTIONS TO NURSING STAFF:***

1. Complete ALL applicable sections and sign where indicated. Incomplete fields may delay the order.
2. A physcian's signature is required on all CONTROL prescriptions OR a verbal order must be phoned in to the backup pharmacy by the nurse/agent or physician. For Non-Control orders, please follow all applicable federal and state laws.
3. For C2 prescriptions, the signed hard copy prescription must be presented to the backup pharmacy or, in the case of a verbal order, the verbal order must be made by the physician himself directly to the backup pharmacy.
4. If submitting a verbal order, call order directly to backup pharmacy and fax a copy to the Diamond Hotline above.

**DO NOT USE THIS FORM for: USM (*through Heritage*) , ICE , Other Insurance or Special Programs**

**Release Meds?** YES | NO

***INSTRUCTIONS TO PHARMACY:***

☐ Check if a Verbal order, authorized by the prescriber, was phoned into the local pharmacy by the prescriber, or prescriber's designee

Pt Last Name _____ First Name _____ DOB: _____ Patient ID: _____

Pt Address _____

Allergies: _____

| Medication Strength and Form | Directions | Quantity |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

***Online Billing Info.***

Group #

PBM: **ASCELLAHEALTH**

BIN: **017522**

PCN: **AC**

**Rejections: 1.800.882.6337, ext 2100**

If you are unable to contact a rep, please release the order and leave a message at ext. 1022 or ext. 1016 and we will make payable the next business day

***Prescriber:***

Signature: _____

Name: _____

License # _____ Dea # _____

Prescriber Address:

***** Backup Pharmacy Please Fill: *****

# of Days: _____ or # of Pills: _____

Amount/balance to be filled by Diamond

# of Days: _____ or # of Pills: _____

****DIAMOND PHARMACY USE ONLY****

Reviewed by Diamond Pharmacist:

Signature: _____

Pharmacy _____

Fax Number:

*(attach additional forms as needed)*