PRESCRIPTION ORDER FORM

PRESCRIBER INFORMATION:

NAME: ______________________________ NPI: ________________________________

ADDRESS:____CITY: _______________________

STATE: ___________ ZIP: _________________PHONE: ____________________________ FAX: __________________

PATIENT INFORMATION:

NAME: ______________________________ DATE OF BIRTH: _____________

PHONE: _____________________________

ADDRESS:____CITY: _______________________

STATE: ___________ ZIP: _________________ALLERGIES: ____

PRESCRIPTION INFORMATION:

LICART™ (DICLOFENAC EPOLAMINE) TOPICAL SYSTEM 1.3%

QUANTITY (circle - multiples of 15): 15 30 OTHER:_________

DIRECTIONS: ____

REFILLS: ____________

PRESCRIBER SIGNATURE: ____ **DATE:** ___________

To E-PRESCRIBE, use the following information:

Name: Highland Specialty Pharmacy
City: Hattiesburg State: Mississippi (MS) Zip: 39402
Pharmacy Type: Retail NPI: 1679833404 NCPDP: 2588842

Highland Specialty Pharmacy will contact the patient via phone & text from 601-268-6033 within 24 hours of receipt of prescription

FAX: 601-268-6690 PHONE: 601-268-6033 TOLL FREE: 855-894-4441
Hours of Operation: Monday - Friday 9am to 5pm CST