PHARMACY ORDER FAX FORM FAX TO: 870-772-0214
Customer Service - 1-844-680-2944

TAGI Pharma, Inc. Support Program

PHYSICIAN INFORMATION

NAME: _____

DEA #: _____ NPI #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ FAX: _____

OFFICE CONTACT: _____ CONTACT PHONE #: _____

PHYSICIAN EMAIL: _____

PRESCRIPTION INFORMATION

ANY KNOWN ALLERGIES: _____

DRUG/STRENGTH	INSTRUCTIONS	QTY	REFILLS

Physician Signature: _____ Date: _____

PATIENT INFORMATION

PLEASE INCLUDE COPY OF FRONT & BACK OF PHARMACY INSURANCE CARD

NAME: _____ PHONE: _____

ADDRESS: _____ DATE OF BIRTH: _____

CITY: _____ STATE: _____ ZIP CODE: _____

LAST FOUR DIGITS OF SOCIAL SECURITY #: _____
(USED FOR INSURANCE VERIFICATION PURPOSES ONLY)

FOR e-PRESCRIBING, please use the following information for processing requests through your system:

Name: CSI Pharmacy **Pharmacy Type:** Retail/ Mail Order/ Specialty
City: Texarkana **State:** AR **Zip:** 71854
NPI #: 1316213168

*There is no Additional Cost to the Patient or Physician for this service
07/18