



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%

QTY (multiples of 15): 15 30 OTHER: _____ REFILLS: _____

DIRECTIONS:

Apply one patch topically to clean, dry, hairless area once daily

Other: _____

FLECTOR® (DICLOFENAC EPOLAMINE) TOPICAL SYSTEM 1.3%

QTY (multiples of 30): 30 60 OTHER: _____ REFILLS: _____

DIRECTIONS:

Apply one patch topically to clean, dry, hairless area BID

Other: _____

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