

Prescription Assistance Program

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Referral from: __BMC __EKL __LJC __LAK
 __LIH __UMC __WOM __Other:_____

Patient Label/Stamp

PLEASE NOTE:

1. Prescription Assistance is only available for patients with established Primary Care Providers/Medical Homes due to the continued documentation necessary to maintain access to medication using this program's resources.
2. Patients must be determined to be eligible for Free Care prior to requesting Prescription Assistance Program evaluation.
3. Prescriptions should be written for a 90 day supply of medication with 3 refills.
4. Every Prescription dispensed by the Outpatient Pharmacy requires payment of a \$6 processing fee by the patient.
5. Medication availability can be determined by searching the Outpatient Pharmacy Formulary, which can be accessed using the MCL Shortcuts' Pharmacy folder's Formulary Icon.

Attending Provider: _____ ID Number: _____

If Patient Label/Stamp is Not Available Complete the Following:

Patient's Name: _____ Date of Referral: ___/___/___

Patient's Mailing Address: _____

Date of Birth: ___/___/___ LIH Medical Record Number: _____

1° Contact No.: (____) _____ - _____ 2° Contact No.: (____) _____ - _____

Email Address: _____

Referring Provider's Signature: _____ ID Number: _____

Provider's Contact Number: _____ - _____ - _____

Provider's Email: _____

Referring Service/Clinic: _____

Clinic Contact Number: _____ - _____ - _____

OFFICE USE ONLY: Appointment Date: ___/___/___ Time: __:__ am/pm.

If not scheduled, Indicate Reason & Recommendation: _____

Reviewing Pharmacy Personnel's Signature: _____

ID Number: _____

Contact Number: _____ - _____ - _____