PEN NEEDLE PRESCRIPTION CHANGE REQUEST

Unifine® Pentips®

trust d.

Tried, true and covered.[1]

Dear Doctor,

I am interested in switching my pen needle prescription to Unifine Pentips.
If you could please complete the below, I would greatly appreciate it.

Thank you!

This section is to be completed by a physician's office:

Please change _____ pen needle prescription to:
(Patient's name)

Unifine Pentips Pen Needles, 100 Count (please indicate size preference):

☐ Ultra-Micro 4mm x 33G	☐ Micro 4mm x 32G	☐ Mini 5mm x 31G	☐ Max-Flow 5mm x 30G	☐ Ultra-Thin 6mm x 32G	☐ Ultra-Short 6mm x 31G	☐ Short 8mm x 31G
NDC: 08470-3560-01	NDC: 08470-3540-01	NDC: 08470-3550-01	NDC: 08470-3555-01	NDC: 08470-3595-01	NDC: 08470-3590-01	NDC: 08470-3530-01

☒ Dispense as written ☒ Do not substitute ☒ Refill _____

Physician signature: _____

Address: _____

Phone: _____

DEA#: _____

Date: _____

This section is to be completed by the patient:

Pharmacy Name: _____

Pharmacy Fax Number: _____

Pharmacy Phone Number: _____

Patient Name: _____ Date of Birth: _____

Address: _____
(Street) (City) (State) (Zip)

Please return this completed form to your preferred pharmacy.

UPRXCHANGEREQ/OMI/0519/2/US

UNIVERSAL FIT[2] | COVERED BY MOST INSURANCE PLANS[1] | MADE IN EUROPE

1.Independent and chain pharmacy co-pay adjudication (April 2016). Actual coverage and co-pay may vary from setting to setting, and insurer to insurer. Data on file. 2. Complete compatibility information available on owenmumford.com