



GOVERNMENT OF THE UNITED STATES VIRGIN ISLANDS  
**DEPARTMENT OF HUMAN SERVICES**

*VI STATE PHARMACEUTICAL ASSISTANCE PROGRAM*

**PRESCRIPTION VERIFICATION FORM**  
***(TO BE COMPLETED BY PHYSICIAN ONLY)***

***PATIENT INFORMATION***

NAME \_\_\_\_\_  
Last First Initial

DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

ADDRESS: (PHYSICAL) \_\_\_\_\_

(MAILING) \_\_\_\_\_

TELEPHONE NUMBER: (HOME) \_\_\_\_\_ (WORK) \_\_\_\_\_ (CELL) \_\_\_\_\_

***PHYSICIAN INFORMATION***

NAME \_\_\_\_\_  
Last First (PRACTICE/SPECIALTY)

ADDRESS: (PHYSICAL) \_\_\_\_\_

(MAILING) \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

**A. Please note any health problem, physical impairment, emotional difficulty, behavioral problem, or facts which may limit full participation in our State Pharmaceutical Assistance Program.**

\_\_\_\_\_  
\_\_\_\_\_

**B. Patient is subject to allergies:**

YES (\_\_\_) NO (\_\_\_)

Codeine \_\_\_\_\_ Sulfa \_\_\_\_\_ Aspirin \_\_\_\_\_ Other \_\_\_\_\_

**C. Patient is subject to:**

☐ asthma                      ☐ sensitive skin                      ☐ sleepwalking                      ☐ nosebleed  
☐ ear ache                      ☐ sinus trouble                      ☐ convulsions                      ☐ high blood pressure  
☐ fainting                      ☐ frequent colds                      ☐ headache                      ☐ motion sickness  
☐ tonsillitis                      ☐ nightmares                      ☐ bed wetting                      ☐ allergies  
☐ eye infection                      ☐ bronchitis                      ☐ kidney problem (describe)\_\_\_\_\_

**D. Patient wears contact lenses (\_\_\_) or glasses (\_\_\_)**

Medical Conditions and Diagnosis: (Check all that apply)

High Blood Pressure \_\_\_\_\_ Diabetes \_\_\_\_\_ Arthritis \_\_\_\_\_

Cancer \_\_\_\_\_ Heart Lung \_\_\_\_\_

Other \_\_\_\_\_

E. To ensure that all patients comply with their medication regimen in a cost contained manner, please provide a list of the patient's CURRENT prescribed medication and the indication for its use.

Medication	Strength (mg)	SIG Directions	Prescribing Doctor	Doctor Phone #	Pharmacy Company	Date

**NOTE: THE SPAP PROVIDES MEDICATION ASSISTANCE TO SENIORS AGE 60 AND ABOVE; TO ENSURE THAT WE PROVIDE ADEQUATE COVERAGE, WE ENCOURAGE PHYSICIANS TO PRESCRIBE GENERICS UNLESS BRAND IS ABSOLUTELY NECESSARY!!!**