

# Prescription Drug Authorization Form

Dear Customer:

- In order for us to ship pharmaceuticals to you, we must have authorization from the physician (Medical Director) responsible for your department. Please fill in your customer information below, have your authorizing physician complete the box below, and send this completed form to us by fax or mail along with copies of all requested licenses. If your agency does not have a Medical Director, but is licensed to purchase prescription products, please send us a copy of all applicable licenses along with this form for our review.
- To purchase controlled substances, we **must** also have a copy of your Medical Director's and/or your agency's Federal DEA license (Form 223) along with this form. Please note that controlled substances can **only** ship to the address listed on the Federal DEA license.
- Schedule III, IV and V controlled substances may be ordered via phone, fax or e-mail once all of the required information is on file.
- Schedule II controlled substances require an original, completed, and signed Federal DEA Form 222 to be sent **each** time an order is placed and must be received before the order may be filled. Please call for information about completing this form properly.

**Customer Number** (if known): \_\_\_\_\_

**Customer Name:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_ **E-Mail:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

**Shipping Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Additional Shipping Locations?** \_\_\_\_\_ If allowing medications to be shipped to multiple addresses initial here & attach list of approved locations.

**Customer License Information** (attach copies of all applicable licenses):

State License Number & Exp. Date: \_\_\_\_\_

State Controlled Substance License & Exp. Date: \_\_\_\_\_

Federal DEA License & Expiration Date: \_\_\_\_\_

## \* THIS SECTION TO BE COMPLETED BY MEDICAL DIRECTOR\*

Please check **one** of the four categories below denoting your level of authorization for the purchase of devices and medications for the above facility; include additional information and approvals where necessary.

**Legend Devices Authorization Only.** *Absolutely No Medications!*

**Limited Authorization for the following Medications and Legend Devices Only:** *List below or attach sheet if necessary*

\_\_\_\_\_

**Unlimited Medications and Legend Devices Authorization.** *Absolutely No Controlled Substances!*

**Unlimited Medications, Controlled Substances, and Legend Devices:** *Please initial **all** approved controlled substances*

Schedule III, IV, & V Controlled Substance Authorization of: (please initial each approved medication)

\_\_\_\_\_ ATIVAN/lorazepam      \_\_\_\_\_ VALIUM/diazepam      \_\_\_\_\_ VERSED/midazolam

\_\_\_\_\_ Other(s) (list here): \_\_\_\_\_

Schedule II Controlled Substance Authorization of: (please initial each approved medication)

\_\_\_\_\_ DEMEROL/meperidine      \_\_\_\_\_ DILAUDID/hydromorphone      \_\_\_\_\_ Fentanyl Citrate

\_\_\_\_\_ Morphine Sulfate      \_\_\_\_\_ Other(s) (list here): \_\_\_\_\_

**By signing below, I hereby authorize the internally-designated representative of this facility to order the above approved devices and/or medications (please send copies of physician's applicable licenses with this form).**

Physician Name (please print): \_\_\_\_\_ Medical License# & Exp. Date: \_\_\_\_\_

Federal DEA License# & Exp. Date: \_\_\_\_\_ State DEA License# & Exp. Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If any change occurs in the above information (including authorizations, license information, and/or authorizing physician) a new Prescription Drug Authorization Form must be submitted with applicable licenses before any additional shipments may be processed.

Southeastern Emergency Equipment  
P.O. Box 1196  
Wake Forest, NC 27588



Phone: 800-334-6656  
Fax: 919-435-5973  
[www.seequip.com](http://www.seequip.com)