

Prescription Fax Form



Patient: Please fill out step 1 and bring this form to your doctor. This prescription request is only authorized when faxed from the physician's office. Please copy this form for your other medication(s).
Physician: Please fully complete steps 2 to 5 below to help ensure timely processing of your patient's prescription.
Questions? Call Customer Service at 1 888 327-9791.

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Step 1. Please complete missing information below.

Member # _____

Member Name (card holder): _____
(First) (Last)

Shipping Address: _____
City State Zip Code

Step 2. Complete Patient Information:

Patient DOB: _____

Please check all that apply:

Allergies:

- None Sulfa Penicillin
- Aspirin Codeine Iodine

Medical Conditions:

- Heart Attack/Angina Heart Failure
- Asthma High B.P.
- Ulcer Glaucoma

Other _____

Step 3. Please Write or Attach Prescription Below.

Prescription watermark security forms will obscure legibility when faxed.

**Prescriber's Name
And
Address Required**



Patient Name:

Address:

Issue Date: ____/____/____

Rx

Refills:

.....
Substitution Permissible - Prescriber Signature
(We cannot accept Signature Stamps)

.....
Dispense as Written - Prescriber Signature
(We cannot accept Signature Stamps)

Step 4. Prescriber Information:

Prescriber Fax No.

Print Prescriber's Name

Step 5. Sign and Fax Back to:

1 800-837-0959

Please do not fax with a cover sheet. We do not accept CII prescriptions via fax. Fax forms will only be accepted if faxed directly from a prescriber's office. Most patients can receive a 90-day supply plus refills up to 1 year where appropriate.



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