

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.

34302



Step 1. Please complete the required information below.

Member Name (Cardholder): _____
(First) (Last)

Shipping Address: _____
(City) (State) (Zip Code)

Step 2. 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 4. Prescriber Information:

Prescriber Fax No.

Print Prescriber's Name

Step 5. Sign and Fax Back to:

1 800 837-0959

Step 3. Please Write or Attach Prescription Below.

Prescription watermark security forms will obscure legibility when faxed.

Prescriber's name and Address required → []

Patient's name and Address required:

Issue Date: ____ / ____ / ____

Rx

Refills:

.....
SUBSTITUTION PERMISSIBLE — Prescriber Signature
(We cannot accept Signature stamps.)

.....
DISPENSE AS WRITTEN — Prescriber Signature
(We cannot accept Signature stamps.)

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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