

YOUR PATIENT WOULD LIKE TO RECEIVE THEIR PRESCRIPTION MEDICATION BY MAIL.

34202 

Please complete ALL information below.

STEP 1 Prescriber Information

Questions? Call 888.327.9791

Note to Prescriber	
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Prescriber Name _____

DEA _____
Required for CIII-CV medications

Secure fax number _____

NPI ▶ _____

STEP 2 Member Information

Member No.

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

(Include all characters. Leave box blank for spaces)

Member Name(card holder): _____

STEP 3 Patient Information

STEP 4 Prescription Information

Please complete or attach prescription below

Patient Name	
DOB	Tel
Ship to address	

Address
City, State, Zip
Telephone

Allergies
 None Sulfa Penicillin
 Aspirin Codeine Iodine

Patient Name _____

Other _____

DOB _____ Issue Date _____

Medical Conditions
 Heart Failure Hypertension
 Heart Attack/Angina Asthma
 Glaucoma Ulcer



Other _____

STEP 5 Return Fax

NO COVER SHEET REQUIRED
**Fax this page ONLY to
800.837.0959**

Refills _____

Prescriber Signature

Substitution Permissible

Prescriber Signature

Dispense as Written

(We cannot accept Signature Stamps)

▶We cannot accept CII prescriptions via fax.
▶Fax forms will only be accepted when sent from a prescriber's office.
▶The printed fax confirmation is proof of receipt.
Most patients can receive a 90-day supply plus refills up to 1 year (as appropriate).



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