



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

34202



Please complete ALL information below.

Questions? Call 1.888.327.9791

STEP 1 Prescriber Information

Note to Prescriber

Prescriber Name

DEA Required for CIII-CV medications

Secure fax number

NPI

STEP 2 Member Information

Member No. (grid)

(Include all characters. Leave box blank for spaces )

Member Name(card holder):

STEP 3 Patient Information

Patient Name, DOB, Tel, Ship to address

- Allergies: None, Sulfa, Penicillin, Aspirin, Codeine, Iodine

Other

- 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 1 800 837-0959

- 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).

STEP 4 Prescription Information

Please complete or attach prescription below

Prescriber Name, Address, City, State, Zip, Telephone

Large empty box for prescription details

Patient Name

DOB Issue Date



Refills

Substitution Permissible Prescriber Signature

Dispense as Written Prescriber Signature

(We cannot accept Signature Stamps)

