

YOUR PATIENT WOULD LIKE TO RECEIVE THEIR PRESCRIPTION MEDICATION BY MAIL. 34202 Please complete ALL information below. Prescriber Information Questions? Call 888.327.9791 STEP 1 Note to Prescriber **Prescriber Name** DEA Required for CIII-CV medications Secure fax number _ NPI . Member Information STEP 2 Member No. (Include all characters.Leave box blank for spaces) Member Name(card holder): _ Patient Information STEP 3 STEP 4 Prescription Information Please complete or attach prescription below _ _ _ _ _ _ _ _ _ _ _ _ _ Patient Name **Prescriber Name** DOB Tel Address City, State, Zip Ship to address Telephone Allergies Penicillin None Sulfa Patient Name Codeine lodine Aspirin DOB_ Issue Date _ Other **Medical Conditions** Heart Failure Hypertension Heart Attack/Angina Asthma Glaucoma Ulcer Other _ STEP 5 Return Fax Refills _ NO COVER SHEET REQUIRED Fax this page ONLY to 800.837.0959 Prescriber Signature Substitution Permissible We cannot accept CII prescriptions via fax. Fax forms wil only be accepted when sent from a Prescriber Signature prescriber's office. **Dispense as Written** The printed fax confirmation is proof of receipt. Most patients can receive a 90-day supply plus refills (We cannot accept Signature Stamps) up to 1 year (as appropriate).



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