

Please complete ALL information below.		
STEP 1 Prescriber Information		Questions? Call 888.327.979
Note to Prescriber		
Prescriber Name		d for CIII-CV medications
ecure fax number	NPI)	
STEP 2 Member Information		
Nember No.		
(Include all characters.Leave box blank for sp	uaces)	
Member Name(card holder):		
STEP 3 Patient Information	STEP 4 Prescription I Please complete or a	Information ttach prescription below
Patient Name		
DOB Tel	Prescriber Name Address	
Ship to address	City, State, Zip Telephone	
Allergies None Sulfa Penicillin		
□ None □ Sulfa □ Penicillin □ Aspirin □ Codeine □ Iodine	Patient Name	
Dther	DOB Is	sue Date
Medical Conditions Heart Failure Hypertension 	R	
☐ Heart Attack/Angina ☐ Asthma ☐ Glaucoma □ Ulcer		
Dther		
STEP 5 Return Fax		
NO COVER SHEET REQUIRED	Refills	
Fax this page ONLY to 800.837.0959	 	
We cannot accept CII prescriptions via fax.	Substitution Permissible	Prescriber Signature
Fax forms wil only be accepted when sent from a prescriber's office.	Dispense as Written	Prescriber Signature
The printed fax confirmation is proof of receipt. Most patients can receive a 90-day supply plus refills up to 1 year (as appropriate).	(We cannot acc	ept Signature Stamps)

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