

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.

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(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	

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

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).

Prescriber Name
Address
City, State, Zip
Telephone

Patient Name _____

DOB _____ Issue Date _____



Refills _____

Substitution Permissible _____ Prescriber Signature

Dispense as Written _____ Prescriber Signature

(We cannot accept Signature Stamps)

