

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

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

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).

STEP 4 ▶ Prescription Information

Please complete or attach prescription below

Prescriber Name
Address
City, State, Zip
Telephone

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Patient Name _____

DOB _____ Issue Date _____



Refills _____

Substitution Permissible _____ Prescriber Signature _____

Dispense as Written _____ Prescriber Signature _____

(We cannot accept Signature Stamps)

