



## New Prescription

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

34202



Please complete ALL information below.

Questions? Call 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.

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(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 \_\_\_\_\_

**R<sub>x</sub>**

Refills \_\_\_\_\_

Substitution Permissible \_\_\_\_\_ Prescriber Signature \_\_\_\_\_

Dispense as Written \_\_\_\_\_ Prescriber Signature \_\_\_\_\_

(We cannot accept Signature Stamps)



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