EXPRESS SCRIPTS®

New Prescription

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.

7	4	9	0	5	4	3	8	5	2	8	0

(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 4 Prescription Information

Please complete or attach prescription below

Prescriber Name
Address
City, State, Zip
Telephone

Patient Name ____________________

DOB ____________ **Issue Date** ____________

Refills ____________

Prescriber Signature
Substitution Permissible

Prescriber Signature
Dispense as Written

(We cannot accept Signature Stamps)

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 wil 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).

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This page was last updated on 06/20/2018.
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