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. 9 2 0 9 1 6 6 1 1

(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** _____

Rx

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).