



Member Information

Cardholder ID #: _____
(Include all characters. Leave box blank for spaces.)

Cardholder name: _____

write for 90 days

STEP 1 Complete all information below.

Prescriber Information

Prescriber Name: _____

Fax#: _____

NPI #: _____
(NPI required for all prescriptions)

DEA #: _____
(DEA required for CIII-CV prescriptions)

Telephone #: _____ - _____ - _____

Not for CII prescriptions

STEP 2 Fill in or attach prescription below

Prescriber Name
Address
City, State, Zip



Write or stamp here
(Fill out one form for each Rx)

Patient Name: _____

Drug: _____

Strength: _____

Quantity: _____

Directions: _____

Refills: _____ (up to 3 refills)



Date: / /

(Stamps are not accepted. Signature required.)
In order for a brand name product to be dispensed, the prescriber must handwrite "brand necessary" or "brand medically necessary" in the space below.

When applicable PRINT Supervising Physician name here ↑

Patient Information

Date of birth:
Telephone #:
Ship to address:

STEP 3

Indicate number of medications on this page.

Have questions?
Call 1 888 327-9791.

For reporting allergies or medical conditions, press option 5 (Monday-Friday 9:00 am - 8:00 pm Eastern.)

STEP 4

Sign this prescription and fax to:

1 800 837-0959

- ◆ Fax from the prescriber's secure fax line.
- ◆ Do not fax with a cover sheet.
- ◆ Incomplete forms will cause a delay in processing.

