



**THIS FORM MUST BE FAXED FROM A PRESCRIBER'S OFFICE TO BE VALID.**

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**PATIENT SECTION**

**Patient:** To have your order processed, you must be registered with and have current credit card and shipping information on file with Walgreens. You can register online at [Walgreens.com/mailservice](http://Walgreens.com/mailservice) or by mail using the form included in your enrollment kit.

**IMPORTANT NOTICE:** It is standard pharmacy practice to substitute generic equivalents for brand-name medications. Walgreens will dispense a generic equivalent if it's available and permitted by your prescriber. If you do not want a generic equivalent or have questions regarding your mail service prescription(s), please call our Customer Care Center at **866-352-3230, TTY 800-573-1833**.

After you are registered, please print your member ID number listed on your ID card, your phone number and address in the space below and give this form to your prescriber to complete and fax to us.

Member ID Number (*Located on card*) \_\_\_\_\_ Patient Phone \_\_\_\_\_

Patient Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

**PRESCRIBER SECTION**

**Prescriber:** Fax this completed form to **Walgreens at 800-332-9581**. Your signature and date are required. Most prescription drug plans allow up to a 90-day supply with three refills.

**Print and use BLACK INK only. NOT VALID FOR CII PRESCRIPTIONS.**

Patient Name \_\_\_\_\_ DOB [MM/DD/YYYY] \_\_\_\_\_

	Medication	Strength	Directions	Qty.	# of Refills	DAW
Rx 1						<input type="checkbox"/>
	Medication	Strength	Directions	Qty.	# of Refills	DAW
Rx 2						<input type="checkbox"/>

Date \_\_\_\_\_ NPI# \_\_\_\_\_ DEA# \_\_\_\_\_ *Required for Controlled Substances*

Prescriber Signature \_\_\_\_\_

Prescriber Name (*Please print*) \_\_\_\_\_

Prescriber Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Prescriber Phone \_\_\_\_\_ Prescriber Fax \_\_\_\_\_  Check box if this is a new fax number

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Redisclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized redisclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

IMPORTANT WARNING: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.

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