EXPRESS SCRIPTS® | The Medco Pharmacy® is now a part of the Express Scripts family of pharmacies.

**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.**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |

(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 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).**

## 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)**

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This page was last updated on 02/11/2014.
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