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.** 8 4 0 2 0 4 0 5 6
(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).**

This page was last updated on .