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. | W | R | X | A | | | | | | | | |

(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).

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