



**Fax 1-800-491-7997**

**5510**

- Physician**, please provide:
- Complete member information
  - Complete prescription information
  - 90 day supply is preferred

Customer service phone number: **1-800-562-6223**  
 Physician's line: **1-800-791-7658**

**Note: Schedule II medications cannot be faxed**

**1. Member information**

Last name		First name		MI	Gender OM OF
Date of birth (mm/dd/yyyy)		Insurance ID number		Phone number with area code	
Delivery address					Apt. #
City		State	ZIP	Alternate phone number with area code	
<b>Drug allergies</b>		<b>Health conditions</b>		<b>Other conditions</b>	
<input type="checkbox"/> Cephalosporins <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Codeine <input type="checkbox"/> None known		<input type="checkbox"/> Erythromycin <input type="checkbox"/> Tetracycline <input type="checkbox"/> Ampicillin <input type="checkbox"/> Aspirin		<input type="checkbox"/> Quinolone <input type="checkbox"/> Others <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> High blood pressure <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Heart condition <input type="checkbox"/> Others	

**2. Physician and prescription information – physician to complete this section**

<b>Medication</b> (Strength, dosage form and formulation)  Directions   Quantity Refills: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Other _____ Dispense as written: <input type="checkbox"/> Yes:		<b>Medication</b> (Strength, dosage form and formulation)  Directions   Quantity Refills: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Other _____ Dispense as written: <input type="checkbox"/> Yes:	
Physician's name		NPI	DEA
Street			
City		State	ZIP
Phone		Date	
Signature			Date

**Sign and fax back to: 1-800-491-7997 [alt fax: 1-760-476-0406]**

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