

Patient: Please fill out steps 2 and 3, then bring this form to your doctor. This prescription request is only authorized when faxed from the physician's office. Please copy this form for your other medication(s).

Physician: Please fully complete steps 1, 4, and 5 below to help ensure timely processing of your patient's prescription.

Questions? Call 1 888 327-9791

34302



EME1917-3



Please complete ALL information below. Incomplete forms cannot be processed. Please print clearly.

STEP 1 ▶ Prescriber Information

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.)

Group/Subgroup: _____

Member Name (cardholder) _____

STEP 3 ▶ Patient Information

Patient Name	
DOB	Tel.
Ship to address	

Allergies

☐ None
 ☐ Sulfa
 ☐ Penicillin
☐ Aspirin
 ☐ Codeine
 ☐ NSAIDS

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

1 800 837-0959

- ▶ Medco cannot accept CII prescriptions via fax.
- ▶ Fax forms will 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 for up to 1 year, when appropriate.



STEP 4 ▶ Prescription Information

Please complete or attach prescription below.

Prescriber Name
 Address
 City, State, Zip
 Telephone

Patient Name _____

DOB _____ Issue Date _____

R_x

Quantity: _____

Refills: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Directions: _____

Prescriber Signature

Substitution Permissible

Prescriber Signature

Dispense as Written

(We cannot accept signature stamps.)