New Prescription

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

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Please complete ALL information below. Incomplete forms cannot be processed. Please print clearly. **STEP 1** Prescriber Information Prescriber Name _ Required for CIII-CV medications Secure fax number _____ **STEP 2** Member Information Group/Subgroup: Member No.: (Include all characters. Leave box blank for spaces.) Member Name (cardholder) _ STEP 4 **STEP 3** Patient Information **Prescription Information** Please complete or attach prescription below. **Patient Name Prescriber Name** Tel. Address DOB City, State, Zip Telephone Ship to address **Allergies** None Sulfa Penicillin DOB _____ Issue Date ____ Aspirin Codeine NSAIDS Other_ **Medical Conditions** Heart Failure Hypertension Heart Attack/Angina Asthma Ulcer Glaucoma Other_ Quantity: STEP 5 ▶ Return Fax Directions: _____ NO COVER SHEET REQUIRED Fax this page ONLY to 1 800 837-0959 Medco cannot accept CII prescriptions via fax. Prescriber Signature Substitution Permissible Fax forms will only be accepted when sent from a prescriber's office. Prescriber Signature The printed fax confirmation is proof of receipt. Dispense as Written (We cannot accept signature stamps.) Most patients can receive a 90-day supply

plus refills for up to 1 year, when appropriate.

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