

**Physician:** Please provide:

- Complete Patient Information
- Complete Prescription Information
- 90 day supply is preferred

Customer Service Phone #: 1-800-562-6223

Physician's Line: 1-800-791-7658

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

Patient's Name:		Sex (circle):	Date of Birth:	Insurance ID #:
Shipping Address:				Phone Number:
City:		State:	Zip:	Alternate Phone Number:

<b>Drug Allergies:</b> <input type="checkbox"/> None Known <input type="checkbox"/> Others: _____ <input type="checkbox"/> Penicillin <input type="checkbox"/> Cephalosporins <input type="checkbox"/> Ampicillin _____ <input type="checkbox"/> Sulfa <input type="checkbox"/> Erythromycin <input type="checkbox"/> Aspirin _____ <input type="checkbox"/> Codeine <input type="checkbox"/> Tetracycline <input type="checkbox"/> Quinolones _____	<b>Health Conditions:</b> <input type="checkbox"/> High Blood Pres. <input type="checkbox"/> Others: _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Arthritis <input type="checkbox"/> High Cholesterol _____ <input type="checkbox"/> Glaucoma <input type="checkbox"/> Asthma <input type="checkbox"/> Thyroid Disorder _____ <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer <input type="checkbox"/> Heart Condition _____
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<b>Medication &amp; Strength:</b>  <b>Directions:</b>   <b>Qty</b>  <b>Refills:</b> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <b>Other:</b> _____ <b>Brand Only:</b> <input type="checkbox"/> YES	
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<b>Medication &amp; Strength:</b>  <b>Directions:</b>   <b>Qty</b>  <b>Refills:</b> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <b>Other:</b> _____ <b>Brand Only:</b> <input type="checkbox"/> YES	
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<b>Medication &amp; Strength:</b>  <b>Directions:</b>   <b>Qty</b>  <b>Refills:</b> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <b>Other:</b> _____ <b>Brand Only:</b> <input type="checkbox"/> YES	
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<b>Medication &amp; Strength:</b>  <b>Directions:</b>   <b>Qty</b>  <b>Refills:</b> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <b>Other:</b> _____ <b>Brand Only:</b> <input type="checkbox"/> YES	
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Physician's Name:		NPI:	DEA:
Street:			
City:		State:	Zip:
Phone:		Fax:	
Signature:			Date:

■ **SIGN and Fax Back to: 1-800-491-7997**

Health care information is personal and sensitive information related to a person's health care. If health care information is included with this fax, it is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without the additional consent of such person whose health care information is attached or as permitted by law is strictly prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.