## **NEW PRESCRIPTION** FAX FORM

86125



C	catamaran	2
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Member Information	$1 \sim 90$
Cardholder ID #:	write for <b>90</b> days
(Include all characters. Leave box blank for	
Cardholder name:	
<b>STEP 1</b> Complete all information below.	
Prescriber Information	NPI #:
Prescriber Name:	
Fax#:	
Not for CII prescriptions	
<b>STEP 2</b> Fill in or attach prescription below	Patient Information
Prescriber Name	Date of birth:
Address	Telephone #:
City, State, Zip	Ship to address:
Write or stamp here	
(Fill out one form for each Rx)	
Patient Name:	STEP 3
Drug:	Indicate number of medications on this page.
Strength:	
Quantity:	Have questions?
Directions:	Call 1 866 834-0449.
	For reporting allergies or
	medical conditions, press option 5 (Monday-Friday 9:00 am - 8:00 pm Eastern.)
Refills:(up to 3 refills)	STEP 4
V	Sign this prescription and fax to:
Date: /	<u>1 866 996-4921</u>
(Stamps are not accepted. Signature required.) In order for a brand name product to be dispensed, the prescriber must handwrite	
"brand necessary" or "brand medically necessary" in the space below.	<ul> <li>Fax from the prescriber's secure fax line.</li> <li>Do not fax with a cover sheet.</li> </ul>
	<ul> <li>Incomplete forms will cause a delay in processing.</li> </ul>
When applicable PRINT Supervising Physician name here 🛧	J



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The provision of the information requested in this form is for your patient's benefit. Catamaran Home Delivery does not compensate for completing this form.