

**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  
 This is not a valid prescription in Arizona.**

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"/> Quinolone <input type="checkbox"/> Erythromycin <input type="checkbox"/> Tetracycline <input type="checkbox"/> Ampicillin <input type="checkbox"/> Aspirin		<input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart condition <input type="checkbox"/> Others	
<b>2. Physician and prescription information – physician to complete this section</b>					
<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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