New Prescription Fax Form

86115

EXPRESS SCRIPTS®

Return Within 48 Hours

- **Not for CII prescriptions**
- **90-day supply, when appropriate**

Have questions? Please call us at 1 888 327-9791

STEP 1 Complete all information below.

Prescriber Information

Prescriber Name: _____

DEA No.: _____
(Only for CIII-CV prescriptions)

Fax number: ___ - ___ - ____

NPI No.: _____

Member Information

Prescription Drug Card Member No.: _____
(Include all characters. Leave box blank for spaces.)

Member Name: _____
(Card Holder)

Patient Information

Patient Name

DOB | **Tel.**

Ship to address

Allergies:

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

Other _____

Medical Conditions: _____

☐ None

STEP 2 Indicate the number of medications on this fax.

☐

Sign this prescription and fax to

1 800 837-0959

- Fax from the prescriber's secure fax line.
- Do not fax with a cover sheet.
- Incomplete forms will cause a delay in processing.

Fill in or attach prescription below

Prescriber Name
Address
City, State, Zip

Write or Stamp Here

Patient Name: _____

DOB: _____

Drug: _____

Strength: _____

Quantity: _____

Directions: _____

_____

Refills: ____

_____
When applicable PRINT Supervising Physician name here ↑

_____ / /

Sign and date here ↑

(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.

_____

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