

YOUR PATIENT WOULD LIKE TO RECEIVE THEIR PRESCRIPTION MEDICATION FROM MEDCO.

34191



Please complete ALL information below. Incomplete forms cannot be processed. Please print clearly.

### STEP 1 ▶ Prescriber Information

Questions? Call 1 888 327-9791

<b>Note to Prescriber</b>	
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Prescriber Name \_\_\_\_\_

DEA \_\_\_\_\_  
*Required for CIII-CV medications*

Secure fax number \_\_\_\_\_

NPI ▶ \_\_\_\_\_

### STEP 2 ▶ Member Information

Member No. \_\_\_\_\_  
(Include all characters. Leave box blank for spaces.)

Group/Subgroup: \_\_\_\_\_

Member Name (cardholder) \_\_\_\_\_

### STEP 3 ▶ Patient Information

Patient Name	
DOB	Tel.
Ship to address	

**Allergies**

- None       Sulfa       Penicillin  
 Aspirin       Codeine       Iodine

Other \_\_\_\_\_

**Medical Conditions**

- Heart Failure       Hypertension  
 Heart Attack/Angina       Asthma  
 Glaucoma       Ulcer

Other \_\_\_\_\_

### STEP 5 ▶ Return Fax

NO COVER SHEET REQUIRED

Fax this page **ONLY** to

**1 800 837-0959**

- ▶ Medco cannot accept CII prescriptions via fax
- ▶ Fax forms will only be accepted when sent from a prescriber's office.
- ▶ The printed fax confirmation is proof of receipt.

Most patients can receive a 90-day supply plus refills up to 1 year where appropriate.

### STEP 4 ▶ Prescription Information

Please complete or attach prescription below.

Prescriber Name Address City, State, Zip Telephone	
Patient Name _____	
DOB _____	Issue Date _____
<b>R<sub>x</sub></b>	
Refills _____	
_____	Prescriber Signature
Substitution Permissible	Prescriber Signature
Dispense as Written	
(We cannot accept signature stamps)	



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Medco facsimile machines are secure and in compliance with HIPAA privacy standards.