medco® **Pharmacy**

New Prescription

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

34202

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

STEP 1 Prescriber Information

Questions? Call 1.888.EASYRX1

Note to Prescriber	

Prescriber Name _____ **DEA** _____
Required for CIII-CV medications

Secure fax number _____ **NPI** _____

STEP 2 Member Information

Member No.

0	3	7	4	2	6	5	1	1	5	6	8

(Include all characters.Leave box blank for spaces)

Member Name(card holder): _____

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 4 Prescription Information

Please complete or attach prescription below

Prescriber Name
Address
City, State, Zip
Telephone

Patient Name _____

DOB _____ **Issue Date** _____

℞

Refills _____

Prescriber Signature
Substitution Permissible

Prescriber Signature
Dispense as Written

(We cannot accept Signature Stamps)

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 wil 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.

medco®