

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. 

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|

(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 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

|   |  |
|---|--|
| <p>Prescriber Name<br/>Address<br/>City, State, Zip<br/>Telephone</p> | <div style="border: 1px solid black; height: 100px; width: 100%;"></div> |
| <p>Patient Name _____</p>   |  |
| <p>DOB _____ Issue Date _____</p>                                     |  |
| <p><b>R<sub>x</sub></b></p>   |  |
| <p>Refills _____</p>  |  |
| <p>_____<br/>Prescriber Signature</p>                                 |  |
| <p>Substitution Permissible _____</p>                                 |  |
| <p>_____<br/>Prescriber Signature</p>                                 |  |
| <p>Dispense as Written _____</p>                                      |  |
| <p><b>(We cannot accept Signature Stamps)</b></p>                     |  |

