

**PRESCRIPTION SECTION**

**Rx** For \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_

Dr \_\_\_\_\_ Dr \_\_\_\_\_  
Dispense as written      Substitution permissible, may substitute

Physician Name (Please print) \_\_\_\_\_

Refills \_\_\_\_\_ Times      Address \_\_\_\_\_

DEA# \_\_\_\_\_ Phone \_\_\_\_\_

**Rx** For \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_

Dr \_\_\_\_\_ Dr \_\_\_\_\_  
Dispense as written      Substitution permissible, may substitute

Physician Name (Please print) \_\_\_\_\_

Refills \_\_\_\_\_ Times      Address \_\_\_\_\_

DEA# \_\_\_\_\_ Phone \_\_\_\_\_

**PrimeMail® Pharmacy Fax Order Form**



**Physician:** Fax completed form to PrimeMail Pharmacy at **877.PRIME.60** (877.774.6360).  
**Patient:** PrimeMail Pharmacy is your mail service pharmacy. Please make every attempt to obtain a new written prescription from your physician and send it with a PrimeMail Pharmacy Order Form and payment to: **PrimeMail Pharmacy, P.O. Box 650041, Dallas, TX 75265-0041**

To facilitate your prescription, follow these steps to obtain your prescription:

- Complete the Member, Patient and Payment Sections below using **black ink** only. A credit card number is required at the time the form is submitted.
- Ask your doctor to fill out the Prescription Section and fax this form to **877.PRIME.60**. Orders not faxed from a licensed physician's office will not be processed.
- Please allow 10 to 14 days for delivery from the date your physician faxes your prescription in.

**By returning this form to PrimeMail, you consent to the use and release of your health information and that of your covered dependents (if you are their guardian or authorized representative) to your health plans and health care providers/agents for health benefits management.**

**DO NOT FAX PRESCRIPTIONS FOR CONTROLLED SUBSTANCES.**

**MEMBER SECTION**

Member ID Number		Member Date of Birth
Member Name (First, Last)	Daytime Phone	Evening Phone
Address		
City	State	Zip

**PATIENT SECTION**

Patient Name (First, last if different from member)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Patient Date of Birth
Patient Email Address		
<b>PATIENT ALLERGIES</b>		<b>PATIENT CONDITIONS</b>
<input type="checkbox"/> Aspirin <input type="checkbox"/> Sulfa <input type="checkbox"/> Codeine <input type="checkbox"/> Tetracycline <input type="checkbox"/> Penicillin <input type="checkbox"/> Other Allergy _____		<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Epilepsy <input type="checkbox"/> Ulcer <input type="checkbox"/> Glaucoma <input type="checkbox"/> Other condition _____ <input type="checkbox"/> Heart condition _____
Physician Name		Physician Phone

**PrimeMail Pharmacy staff may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product. PrimeMail Pharmacy will dispense FDA-approved generic equivalents when available and appropriate.**

**PAYMENT SECTION**

Credit Card Number	Expiration Date (MM/YYYY)
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> American Express <input type="checkbox"/> Discover <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa	Credit Card Holder's Signature