

---

## Prescription Fax Form

---

**Plan Member:** Please take this form to your doctor for completion. This form can only be submitted by your doctor.

Please note: Your medication will be delivered to you within 4 to 7 days after we receive the faxed prescription from your doctor. Therefore, when placing your order, you should have at least a 14-day supply of that medication on hand.

**Prescriber:** Please take a moment to review the information in this form. Based on feedback from physicians' offices like yours, we have revised the form to make it easier to complete.

This form can be used to fax prescriptions directly to our mail service pharmacy for all of your Medco Health patients. Feel free to make copies of this form, and use it each time you send a prescription to our Medco Health mail service pharmacy.

---

### Please complete the form in its entirety by following the steps below:

- STEP 1:** Fill in both the Subscriber (cardholder) and the Patient information.
- STEP 2:** Check to see if your office's secure fax is listed correctly. A secure fax location is defined as an area where patient information is kept confidential.
- STEP 3:** Indicate the medical information requested for new patients or for patients with changes in health.
- STEP 4:** Please tape the prescription from your prescription pad here. With regard to your patient's plan benefit:
- Most patients can receive up to a 90-day supply of medication with 4 refills.
  - Medications listed on your patient's formulary can help to reduce your patient's total co-pay amount.

<b>Please make sure to include the following information on the prescription (using your own prescription blank):</b>
---

- |   |
|---|
| <ul style="list-style-type: none"><li>→ Patient's First and Last Name</li><li>→ Patient's Date of Birth</li><li>→ Date Written</li><li>→ Medication Name/Strength</li><li>→ Quantity/Number of Refills (Most patients can receive up to a 90-day supply and 4 refills.)</li><li>→ Directions</li><li>→ Prescriber's Signature (Signature stamps are not accepted.)</li><li>→ <b>Prescriptions for controlled substances will only be accepted where allowed by prescriber state regulations.</b></li><li>→ <b>We do not accept Schedule two (C2) prescriptions via fax.</b></li></ul> |
|---|

Completing all of the fields on the form helps to ensure timely processing for your patients.

**Fax the completed form without a cover sheet to 1-800-837-0959**

---

**Confidentiality Notice:** This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.

---

Medco Health manages this patient's pharmacy benefit at the request of his or her plan sponsor.

**Prescription Fax Form**



**Patient:** Do not fax or mail. **This form can only be submitted by your doctor to ensure only faxed prescriptions that are authorized by your prescriber are accepted.**

**Prescriber:** Your patient would like to receive this prescription through the **Medco By Mail™**. Patients can save time and money with this service.

We are requesting an approval of this prescription from you.

**Please complete and fax this form to us at 1-800-837-0959.** Thank you. If you have questions, call us at 1-888-327-9791.

64111



**Step 1** Fill in both the Subscriber and the Patient information below.

**Prescription Drug Card Member # :**

(usually different than the health plan ID #.)

**Subscriber Information (card holder):**

Name:(First) \_\_\_\_\_ (Last) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Name:(First) \_\_\_\_\_ (Last) \_\_\_\_\_ DOB: \_\_\_\_\_

**Step 2** Confirm your office's secure fax #.

Check the box to indicate a change, and write in the correct#.

New fax # :

**Step 3** Complete for new patients or for patients with changes in health.

Please check all that apply:

**Allergies:**

- None  Sulfa  Penicillin
- Aspirin  Codeine  Iodine

**Medical Conditions:**

- Heart  Asthma  High B.P.
- Ulcer  Glaucoma
- Other \_\_\_\_\_

**Step 4** Please tape the prescription from your prescription pad here. (Most patients can receive up to a 90-day supply and 4 refills.)

**Fax the completed form to: 1 800 837-0959**

Medco Health fax printers are secure and in compliance with the HIPAA Privacy Standards.

**TAPE PRESCRIPTION HERE**

**Please confirm you have included:**

*On the form:*

- Subscriber's Drug Card Number

*On the prescription:*

- Patient's Full Name
- Patient's Date of Birth
- Patient's Address
- Date Prescription Written
- Your Signature (Signature stamps are not accepted.)
- **We do not accept Schedule two (C2) prescriptions via fax.**
- **Prescriptions for controlled substances will only be accepted where allowed by prescriber state regulations.**

64111



**Confidentiality Notice:** This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.

Medco Health manages this patient's pharmacy benefit at the request of his or her plan sponsor.