

PRESCRIPTION SECTION

Rx For _____ Date _____
 Address _____ Phone _____

Dr _____
Prime Therapeutics may dispense a generically equivalent drug unless practitioner writes "Brand Medically Necessary" on prescription.

Prescriber Name (Please print) _____

Refills _____ Times _____ Address _____

DEA# _____ Phone _____

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Rx For _____ Date _____
 Address _____ Phone _____

Dr _____
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Refills _____ Times _____ Address _____

DEA# _____ Phone _____

PrimeMail® New Prescription Fax Order Form

Prescriber: Fax completed form to PrimeMail toll free **888.214.1811**.

Please call 888.215.3015 with questions.

Due to regulatory requirements, prescriptions for class II controlled substances must be mailed to PrimeMail. Some states require prescriptions for class III through V controlled substances to be mailed in as well. Laws and regulations vary by state.

Patient: Follow these steps to obtain your prescription:

- Complete all the sections below using **black ink**. A credit card number is required.
- Ask your prescriber to complete the Prescription Section and to fax the form from the prescriber's office or send the form to: PrimeMail, P.O. Box 27836, Albuquerque, NM 87125-7836.

Note: Orders not faxed from a licensed prescriber's office will not be processed.

- Your prescription will be delivered within 5 to 10 business days from receipt of order.

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 in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

MEMBER SECTION

Member ID			Date of Birth (MM/DD/YYYY)	
First Name	Middle Initial	Last Name	Phone	
Shipping Address (Please do not use a P.O. Box)			E-mail Address	
City	State	Zip	Prefer contact by: <input type="checkbox"/> E-mail <input type="checkbox"/> Phone	

PATIENT SECTION

First Name	Middle Initial	Last Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY)
Patient E-mail Address				

DRUG ALLERGIES

- None Codeine Sulfa
 Aspirin Erythromycin Penicillin
 Other:

HEALTH CONDITIONS

- Arthritis Diabetes Glaucoma High cholesterol
 Asthma Depression Heart condition Hypertension
 Other:

Prescriber Name	Prescriber Phone
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PrimeMail may contact your prescriber for clarification and safety purposes which may result in your prescriber prescribing a different, clinically appropriate product. Pharmacy law may permit pharmacists to substitute a less expensive, FDA-approved generically equivalent medication for a brand-name medication unless you or your prescriber indicate otherwise. Some health plans require the patient to pay the difference between generic and brand-name costs.

PAYMENT SECTION

Credit Card Number	Expiration Date (MM/YY)
<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"/> Master Card <input type="checkbox"/> Visa	
<input type="checkbox"/> Or use credit card on file ending <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Credit Card Holder's Signature