PRESCRIPTION Fax Form:
Special Care Pharmacy Medications Only

Physician: Please fully complete steps 1 to 4 below to help ensure timely processing of your patient's prescription.

Questions? Call the Special Care Pharmacy at 1 800 987-4904.

Form No. 34444

Fax to: 1 800 391-9707

Step 1 Please complete the **Member and/or Patient** information below.

Prescription Drug Card Member # or Insurance Card #

SCP

Member Name (card holder): (First) (Last)

Patient Information:

Name: (First) (Last) DOB:

Address:

City: State Zip Code Phone #

Step 2

Print Prescriber's Name:

Write in secure fax No. below.

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 Attack/Angina
☐ Heart Failure(weak heart)
☐ Asthma ☐ High B.P.
☐ Ulcer ☐ Glaucoma

ICD-9 &/or conditions:

Other

Step 4 To ensure continuation of your patient's therapy, please fax completed form to: **1 800 391-9707**

Please do not fax with cover sheet. For verification purposes, please fax directly from your office.

Your fax machine receipt is confirmation that we have received your fax.

℞

TAPE PRESCRIPTION HERE

Most patients can receive up to a 90-day supply, plus refills up to one year (as appropriate).

Please confirm you have included:

On the form:

- Prescription Drug Card Member # or Insurance Card #
- Prescriber's Last Name

On the prescription:

- Patient's full name
- Patient's date of birth
- Date prescription is written
- Your signature

Please remember ...

- We do not accept Schedule II (Ⓒ) prescriptions via fax
- **FAX FORMS WILL ONLY BE ACCEPTED IF FAXED DIRECTLY FROM A PRESCRIBER'S OFFICE. WE CANNOT ACCEPT PRESCRIPTIONS FAXED BY PATIENTS.**

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