

**1 Member and physician information** Please use black or blue ink. One form per member.

Member ID number			Gender <input type="checkbox"/> M <input type="checkbox"/> F		
Last name		First name		MI	
Delivery address					Apt. #
City	State	ZIP Code		Phone number (list in order of preference) (circle one)	
Date of birth / /	Email address			( ) M H W	
Physician name		Physician phone number ( )		( ) M H W	
				( ) M H W	

**2 Health history** Best time to be reached: AM PM

<b>Drug allergies:</b> <input type="checkbox"/> Amoxicil/Ampicillin <input type="checkbox"/> Erythromycin <input type="checkbox"/> None known <input type="checkbox"/> Aspirin <input type="checkbox"/> NSAIDs <input type="checkbox"/> Sulfa <input type="checkbox"/> Cephalosporins <input type="checkbox"/> Penicillin <input type="checkbox"/> Tetracyclines <input type="checkbox"/> Codeine <input type="checkbox"/> Quinolones <input type="checkbox"/> Others: _____			<b>Health conditions:</b> <input type="checkbox"/> Arthritis <input type="checkbox"/> Glaucoma <input type="checkbox"/> None known <input type="checkbox"/> Asthma <input type="checkbox"/> Heart condition <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer <input type="checkbox"/> High blood pressure <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Diabetes <input type="checkbox"/> High cholesterol <input type="checkbox"/> Others: _____		
List all prescription, over-the-counter and herbal drugs taken regularly: (use additional sheet if necessary)					

**3 Refills** To order home delivery refills, enter your prescription number(s):

1: \_\_\_\_\_ 2: \_\_\_\_\_ 3: \_\_\_\_\_ 4: \_\_\_\_\_  
 5: \_\_\_\_\_ 6: \_\_\_\_\_ 7: \_\_\_\_\_ 8: \_\_\_\_\_

**4 Pharmacy processing**

*Generic substitution:* FDA-approved generic equivalents will be dispensed for brand-name drugs whenever possible, unless you or your physician indicate otherwise. Brand-name drugs may be subject to a higher cost. Generic equivalents are usually less expensive than brand-name drugs. If we dispense a brand-name drug, you may be responsible for a higher copay and/or the difference between the brand and generic price of each drug. If allowed by your prescriber, we will dispense a generic equivalent unless you check this box.  I do not accept a generic equivalent.

*Keep on file:* If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them here:

Notes to pharmacy:

**5 Payment and shipping information** Do not send cash.

Standard delivery is included at no charge. Most prescription orders arrive within 7 days from the date your order is received. We will contact you if there is an extended delay in delivering your medicine. Please call **800.424.8274 (TTY 711)** if you have any questions. Once shipped, medicine may not be returned for a refund or adjustment. Visit [PrimeTherapeutics.com/PatientForms](http://PrimeTherapeutics.com/PatientForms) to download additional order forms.

Ship overnight (additional charges will apply). Please call to verify pricing. No P.O. Box overnight shipping.       Check enclosed. All checks must be signed and made payable to Prime Therapeutics Pharmacy.

Charge to my new credit card.       Charge to my credit card on file.

I authorize Prime Therapeutics Pharmacy to charge the following amount to my credit/debit card without prior notification:  
 \_\_\_\_\_ up to \$150    \_\_\_\_\_ up to \$250    \_\_\_\_\_ up to \$ \_\_\_\_\_ (other amount greater than \$250)

For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance and other such expenses related to prescription orders. By supplying my credit card number, I authorize Prime Therapeutics Pharmacy to maintain my credit card on file as payment method for any future charges. To modify payment selection, Customer Service can be contacted at any time at **800.424.8274 (TTY 711)**.

Cardholder signature:	Date:
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Credit card number (VISA®, MasterCard®, Discover® or American Express® are accepted) and expiration date (month/year)

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**6 Complete your order form**

Mail this completed order form with your new prescription(s) to Prime Therapeutics Pharmacy, P.O. Box 620968, Orlando, FL 32862. DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.