# Medication Request

**Pharmacy:** **Toll Free:**

**Fax Prescription to:**

---

**Patient Information**

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Diagnosis: _____

| #/Size | Medication/Strength/Dosage/Form | SIG | Refills |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**ID#** _____ **GRP#** _____ **PCN#** _____ **BIN#** _____

**Insurance Phone #** _____ **Medically Necessary:** _____

**Prescriber Signature:** _____ **Date:** ____/____/_____

Physician Name: _____ Office Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Lic#: _____ DEA# (required only for scheduled medications)_____

*This Rx Pad was provided courtesy of . Valid only at with signature.

***We accept e-scribe***