# NEW PRESCRIPTION FAX FORM

86125

catamaran™

## Member Information

write for 90 days

Cardholder ID #: _____

(Include all characters. Leave box blank for spaces.)

Cardholder name: _____

## STEP 1 Complete all information below.

### Prescriber Information

Prescriber Name: _____

Fax#: _____

NPI #: _____
(NPI required for all prescriptions)

DEA #: _____
(DEA required for CIII-CV prescriptions)

Telephone #: ___ - ___ - ____

**Not for CII prescriptions**

## STEP 2 Fill in or attach prescription below

**Prescriber Name**
**Address**
**City, State, Zip**

Rx

Write or stamp here

(Fill out one form for each Rx)

**Patient Name:** _____

**Drug:** _____

**Strength:** _____

**Quantity:** _____

**Directions:** _____

_____

**Refills:** _____**(up to 3 refills)**

**X** _____ **Date: / /**

(Stamps are not accepted. Signature required.)
In order for a brand name product to be dispensed, the prescriber must handwrite "brand necessary" or "brand medically necessary" in the space below.

_____

_____
When applicable PRINT Supervising Physician name here ↑

### Patient Information

**Date of birth:**

**Telephone #:**

**Ship to address:**

## STEP 3

**Indicate number of medications on this page.**

**Have questions?**
**Call 1 866 834-0449.**

**For reporting allergies or medical conditions, press option 5**
**(Monday-Friday 9:00 am - 8:00 pm Eastern.)**

## STEP 4

**Sign this prescription and fax to:**

# 1 866 996-4921

- Fax from the prescriber's secure fax line.
- Do not fax with a cover sheet.
- Incomplete forms will cause a delay in processing.



*The provision of the information requested in this form is for your patient's benefit. Catamaran Home Delivery does not compensate for completing this form.*