PRESCRIPTION AUTHORIZATION FAX FORM

Pharmacy (toll free) Fax # 844-922-7379



CareFirst Specialty Pharmacy

400 Fellowship Road, Suite 100 Mount Laurel, NJ 08054

Office: 856-267-0528 / Toll Free: 844-822-7379 Fax: 800-786-1405 or 844-922-7379

> e-mail: fax@cfspharmacy.com www.cfspharmacy.com

Dear Patient,

Thank you for choosing CareFirst Specialty Pharmacy.

To order a prescription medication, a prescription from a US-licensed prescriber is required. For your convenience, and for the convenience of your prescriber, please feel free to utilize the following form. Please print this PDF document and fill out your contact information.

IMPORTANT: Deliver the fax form to your prescriber for further processing.

State and Federal pharmacy laws stipulate that prescriptions may only be faxed to a licensed pharmacy

from a US-licensed prescriber.

PATIENT

Step 1: You can call us to setup a new account for you or proceed to Step 2.

Step 2: PRINT the Rx Authorization FAX Form & fill in your contact info under Section A - Patient

Step 3: BRING this to your prescriber for authorization. (We cannot accept any prescriptions unless faxed from the prescriber).

PRESCRIBER

Step 4: COMPLETE FORM

Step 5: FAX to CareFirst Specialty Pharmacy to 1-800-786-1405 or if you prefer you may call in the prescription verbally over the phone at 1-844-822-7379

Ordering from CareFirst is easy once we get your patient's prescription on file. If you have any questions, or wish to place your order by phone, feel free to call us any time at 844-822-7379.

Thank You, CareFirst Pharmacy Staff

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PRESCRIPTION AUTHORIZATION FAX FORM

Pharmacy (toll free) Fax 800-786-1405

ATTENTION PRESCRIBER: Thank you for choosing CareFirst to fill a prescription for your client's medication(s). If you have any questions, please call 844-822-7379.

			SECTION A: PAT	IENT – Plea	se print information	on below.	
PATIENT		First Name	Last Name			_	
ILLING DDRESS HONE						SHIPPING	
		Address			ADDRESS (if different)		
		City State		Zip EMAIL		PREFERRED SHIPPING METHOD Ground Second Day Air Ove	
	SECT	ION B: PRES	CRIBER – Please prin				800-786-1405.
RESCR	IBER		***** This A	rea for Pr	escriber Use O	nly *****	
		First Name	t Name Last Name		NPI#	DEA # (for contro	ols)
INIC		Office Name				Bill to	Ship to
IONE		City	State FAX		Zip	— Patient	Patient
1	Patient Na	me				Sex	Age/DOB
	Compounded Medication						
	Strength		Dosage Form	Size	Quantity	Addt'l # of Refills	Other
	Directions	for Use:	1		'	1	
2	Patient Name				Sex	Age/DOB	
	Compounded Medication						
	Strength		Dosage Form	Size	Quantity	Addt'l # of Refills	Other
	Directions	for Use:	I		ı		1
Pleas	e indicate a	ny known allergie	es/medical conditions:				
Pleas	e list any ad	Iditional medicati	on that the patient is taking:				
		Signature rections and num	Name			Date	

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