



Toll Free Phone 877-291-1122 ~ Toll Free Fax 877-291-1155  
4010 Wedgeway Court ~ Earth City, MO ~ 63045

**Prescription Order Form**  
**Fax to (877) 291-1155**

**Patient Information:**

Name \_\_\_\_\_  Male  Female Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Allergies \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**Please Attach a Copy of Insurance Card(s)**  
**(Front and Back)**

Diagnosis / ICD9 Code \_\_\_\_\_

**Medications:**

**Rx:** \_\_\_\_\_ Dose: \_\_\_\_\_  
SIG \_\_\_\_\_ Dispense Quantity: \_\_\_\_\_ Refill: \_\_\_\_\_

**Rx:** \_\_\_\_\_ Dose: \_\_\_\_\_  
SIG \_\_\_\_\_ Dispense Quantity: \_\_\_\_\_ Refill: \_\_\_\_\_

**Rx:** \_\_\_\_\_ Dose: \_\_\_\_\_  
SIG \_\_\_\_\_ Dispense Quantity: \_\_\_\_\_ Refill: \_\_\_\_\_

**Rx:** \_\_\_\_\_ Dose: \_\_\_\_\_  
SIG \_\_\_\_\_ Dispense Quantity: \_\_\_\_\_ Refill: \_\_\_\_\_

**Prescribing Physician Information:**

Physician Signature \_\_\_\_\_ / \_\_\_\_\_ Date \_\_\_\_\_  
(Substitutions Permitted) (Dispense as Written)

Physician Name \_\_\_\_\_ Practice/Facility Name \_\_\_\_\_ Physician Specialty \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email Address \_\_\_\_\_

DEA # \_\_\_\_\_ NPI # \_\_\_\_\_

Name of Contact Person \_\_\_\_\_ Contact Person #, ext or email \_\_\_\_\_