Rx

FOR: _____ DATE: _____

ADDRESS: _____ TEL: _____

Facsimile Not valid for CII prescriptions
Valid only at Walgreens Healthcare Plus

Dr: _____ Dr: _____
DISPENSE AS WRITTEN — SUBSTITUTION PERMISSIBLE MAY SUBSTITUTE

PHYSICIAN NAME (PLEASE PRINT): _____

REFILL _____ TIMES ADDRESS _____

DEA # _____ TELEPHONE # _____

Rx

FOR: _____ DATE: _____

ADDRESS: _____ TEL: _____

Facsimile Not valid for CII prescriptions
Valid only at Walgreens Healthcare Plus

Dr: _____ Dr: _____
DISPENSE AS WRITTEN — SUBSTITUTION PERMISSIBLE MAY SUBSTITUTE

PHYSICIAN NAME (PLEASE PRINT): _____

REFILL _____ TIMES ADDRESS _____

DEA # _____ TELEPHONE # _____

B593/2-01

FAX ORDER FORM
for Priority Health

INTERCOM: PRIOR **UPI NO.: PRY001**

1 0 9

PHYSICIAN: Please fax fully completed form to Walgreens Healthcare Plus: **1-800-573-4719.**
TO THE PATIENT: If you have sent a prescription to *Merck-Medco* and it still has refills remaining, you cannot obtain the refills through that pharmacy after *March 31, 2001*. Walgreens Healthcare Plus will be your new mail service pharmacy. Please make every attempt to obtain a new written prescription from your doctor and send it with an order form and payment to:

Walgreens Healthcare Plus, 7357 Greenbriar Parkway, Orlando, FL 32819-8917

If you are unable to make an appointment with your doctor, follow these steps to obtain your prescription:

1. Fully complete the Employee, Patient and Payment Information sections below using **black ink** only. *A credit card number is required at the time the form is submitted.*
2. Have your doctor supply the prescription information requested using prescriber's form.
3. Have your doctor fax the form to the number above. **IMPORTANT:** ***To be valid, the prescription must be faxed from your doctor's office.***
4. Please allow 2 weeks for delivery from the date your physician faxes your prescription in.

PLEASE NOTE: By submitting this form, you have authorized release of all information to Walgreens Healthcare Plus (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan.

1. CONTRACT HOLDER INFORMATION

Priority Health Contract No. -00		Date of Birth
Name (First, Last)	Daytime Phone ( )	Evening Phone ( )
Address (please do not use P.O. box)		
City	State	ZIP Code

2. PATIENT INFORMATION

Patient Name (First, Last if different from employee)	☐ Male ☐ Female	Patient Date of Birth (Mo/Day/Yr) / /

PATIENT ALLERGIES:
☐ 32-Codeine ☐ 70-Penicillin
☐ 87-Sulfa ☐ 93-Tetracycline
☐ Other (list)

PATIENT HEALTH CONDITIONS:
☐ 200-Diabetes ☐ 300-Hypertension ☐ 400-Heart Disease
☐ 500-Glaucoma ☐ 600-Stomach Disorders ☐ 700-Thyroid Disorders
☐ 800-Arthritis ☐ Other (list):

Dr.'s Name	Dr.'s Phone ( )

3. PAYMENT INFORMATION

PLEASE NOTE: It is standard pharmacy practice to substitute generic equivalents for brand drugs whenever possible. You will receive generic substitutes whenever possible, unless your physician requests and your health plan authorizes brand drugs or you specify otherwise (see below).

☐ By checking this box, I elect to receive brand drugs for all prescriptions in this order whenever possible. By making this choice, I understand that under my benefit plan, I may be responsible for a higher co-payment and/or the difference between the brand and generic price of each drug.

CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express) CREDIT CARD EXP.

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐/☐☐