## 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: PA	IIENI – Plea	se print informatio	on below.	
PATIENT	-	First Name	Last Name			_	
ILLING DDRESS		Address				SHIPPING ADDRESS	
	-					(if different)	
HONE		City State		Zip EMAIL		PREFERRED SHIPPING METHOD	
	SECT	ON B: PRES	CRIBER – Please prir	nt prescriptio	on info (or attach F	X below) and fax to	800-786-1405.
			***** This A	rea for Pr	escriber Use O	nly *****	
RESCR	IBER						
LINIC		First Name Last Name NPI #			NPI#	DEA # (for controls)	
		Office Name				Bill to	Ship to
		City	State		Zip	Patient	Patient
HONE			FAX			Email	
	<b>D</b> (1) (1)					Ser	1
1	Patient Nan	ne				Sex	Age/DOB
	Compounde	ed Medication					
	Strength		Dosage Form	Size	Quantity	Addt'l # of Refills	Other
	Directions f	or Use:					
2	Patient Nar	Patient Name				Sex	Age/DOB
	Compound	Compounded Medication					
	Strength		Dosage Form	Size	Quantity	Addt'l # of Refills	Other
	Directions f	or Use:					
Pleas	e indicate ar	ny known allergie	es/medical conditions:				
			on that the patient is taking:				
	ung du						
Droc	criber's S	Signaturo	Name	1		Date	
		ections and num	ber of refills)				

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