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: 856-267-0529 / Toll Free: 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 1-844-922-7379 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

PRESCRIPTION AUTHORIZATION FAX FORM

Pharmacy (toll free) Fax
844-922-7379

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: PATIENT – Please print information below.

PATIENT _____
First Name Last Name

BILLING ADDRESS _____
Address
_____
City State Zip

SHIPPING ADDRESS (if different) _____

PREFERRED SHIPPING METHOD
☐ Ground ☐ Second Day Air ☐ Overnight

PHONE _____ EMAIL _____

SECTION B: PRESCRIBER – Please print prescription info (or attach RX below) and fax to 844-822-7379.

******* This Area for Prescriber Use Only *******

PRESCRIBER _____
First Name Last Name NPI # DEA # (for controls)

CLINIC _____
Office Name
_____
City State Zip

Bill to	Ship to
☐ Office	☐ Office
☐ Patient	☐ Patient

PHONE _____ FAX _____ Email _____

1	**Patient Name**			**Sex**		**Age/DOB**
	Compounded Medication					
	Strength	**Dosage Form**	**Size**	**Quantity**	**Addt'l # of Refills**	**Other**
	Directions for Use:					

2	**Patient Name**			**Sex**		**Age/DOB**
	Compounded Medication					
	Strength	**Dosage Form**	**Size**	**Quantity**	**Addt'l # of Refills**	**Other**
	Directions for Use:					

Please indicate any known allergies/medical conditions: _____

Please list any additional medication that the patient is taking: _____

_____ _____ _____
Prescriber's Signature Name Date
(Please review directions and number of refills)