For: ______________________________ Date ___________

Address: __________________________ Phone ____________

RX

Dr: _______________________ Dr. ____________________

Dispense as Written Substitution Allowed

Physician Name (Please Print) ____________________________

Refill ______ Address ________________________________

DEA# _______________ Telephone # ____________________

For: ______________________________ Date ___________

Address: __________________________ Phone ____________

RX

Dr: _______________________ Dr. ____________________

Dispense as Written Substitution Allowed

Physician Name (Please Print) ____________________________

Refill ______ Address ________________________________

DEA# _______________ Telephone # ____________________

FAX ORDER FORM TO: 877-283-9171

To the Physician: Please fax this form to Eagle Pharmacy to help facilitate this patient's prescription order.

To the patient: 1) Fully complete the Patient and Insurance Information requested below. 2) Have your doctor supply the prescription information requested using the Rx form on the left. 3) Ask your doctor to fax this form to the fax number shown above. 4) Make certain a valid credit card is on file with Eagle Pharmacy to ensure your order may be processed without delay.

PATIENT INFORMATION

Patient Last Name	Patient First Name	Gender	Birth Date
List Allergies: 1.	2.	3.	None
Physician Last Name	Physician First Name	Physician Telephone	

INSURANCE INFORMATION

Member Last Name	Member First Name	Gender	Birth Date
Mailing Address			
Group Number	Member ID #	Telephone number	
PCN#	BIN#		

☐ By checking this box, I elect to receive only brand drugs for all prescriptions in this order, whenever possible. If you have insurance that covers your prescriptions, that insurance will be billed according to the insurance plan requirements and program rules, and you will be responsible for the insurance co-pay/coinsurance as applicable.

DUE TO FEDERAL REGULATIONS EAGLE PHARMACY CAN ONLY ACCEPT PRESCRIPTIONS FROM PHYSICIANS