



Prescription Drug Plan: \_\_\_\_\_

**THIS FORM MUST BE FAXED FROM A PRESCRIBER'S OFFICE TO BE VALID.**

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**PATIENT SECTION**

**Patient:** To have your order processed, you must be registered with Walgreens Mail Service. You can register online at [Walgreens.com/PrimeMail](http://Walgreens.com/PrimeMail) or by mail using the form included in your enrollment kit.

**IMPORTANT NOTICE:** Generic equivalents are less expensive than brand name drugs. If we dispense a brand name drug, you may be responsible for a higher copayment and/or the difference between the brand and generic price of each drug. If allowed by your prescriber, we will dispense a generic equivalent unless you check this box.  I do not accept a generic equivalent.

After you are registered, please print your member ID number, BIN, and PCN listed on your ID card, and your phone number and address in the space below. Give this form to your prescriber to complete and fax to us.

Member ID Number (Located on card) \_\_\_\_\_ BIN (located on card) \_\_\_\_\_ PCN (located on card) \_\_\_\_\_

Patient Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_ Patient Phone \_\_\_\_\_ - \_\_\_\_\_

**PRESCRIBER SECTION**

**Prescriber:** Fax this completed form to **Walgreens Mail Service at 800-332-9581**.  
**Your signature and date are required.** Most prescription drug plans allow up to a 3 month supply with three refills. **NOT VALID FOR CII PRESCRIPTIONS.**

Send eRx prescriptions to: Walgreens Mail Service  
Store #03397  
8350 S River Pkwy  
Tempe, AZ 85284-2615

Patient Name \_\_\_\_\_ DOB [MM/DD/YYYY] \_\_\_\_\_

	Medication	Strength	Directions	Qty.	# of Refills	DAW
Rx 1						<input type="checkbox"/>
	Medication	Strength	Directions	Qty.	# of Refills	DAW
Rx 2						<input type="checkbox"/>

Date \_\_\_\_\_ NPI# \_\_\_\_\_ DEA# \_\_\_\_\_ *Required for Controlled Substances*

Prescriber Signature \_\_\_\_\_ Prescriber Signature \_\_\_\_\_  
 Dispense as written Brand medically necessary  Generic substitution permitted

Prescriber Name (Please print) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Prescriber Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Prescriber Fax \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Check box if this is a new fax number

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Redisclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized redisclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

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