

PRESCRIPTION REQUEST FORM

SECTION A: TO BE COMPLETED BY MEMBER

Name (Last)	(First)	(M.I.)	Envision Rx Member ID#
<hr/>			<hr/>
Address:			Area Code and Phone #
<hr/>			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Name of patient:			Date of Birth:
<hr/>			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

SECTION A: TO BE COMPLETED BY PHYSICIAN

Name of Patient:	Date:
<hr/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Name of Medication:	Quantity to be dispensed:
<hr/>	<input type="text"/> <input type="text"/> <input type="text"/> <i>Mail order will cover up to a 90 day supply</i>
Instructions For Use:	
<hr/>	
<hr/>	
Number of Refills:	
<input type="text"/> <input type="text"/> <input type="text"/> <i>Mail order will cover up to a 90 day supply</i>	
Physician's Name: <i>Please Print</i>	Physician's Signature: <i>Stamps NOT ACCEPTED</i>
<hr/>	<hr/>
Area Code and Phone #	DEA #
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Mail Prescriptions To:

Orchard Pharmaceuticals
P.O. Box 3094
North Canton, OH 44720

Toll Free: 1-866-909-5170
Fax: 1-866-909-5171
Website: www.orchardrx.com

Call: Monday -Friday: 8:00am - 8:00pm (EST)
Fax: Prescriptions May Be Faxed Directly From The Physician's Office 1-866-909-5171

