


1 Please fill out Section 1, then have your physician fill out Section 2 and FAX it to 1-800-491-7997.
NOTE: THIS FAX IS VOID UNLESS RECEIVED DIRECTLY FROM YOUR PHYSICIAN'S OFFICE.

Primary Member ID Number		(Additional coverage, if applicable) Secondary Member ID Number	
Last Name		First Name	MI
Delivery Address			Apt. #
City	State	ZIP	Phone Number with Area Code
Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Email	
Medication Allergies: <input type="checkbox"/> Amoxil/Ampicillin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Sulfamethoxazole <input type="checkbox"/> Aspirin <input type="checkbox"/> NSAIDs <input type="checkbox"/> Tetracyclines <input type="checkbox"/> Cephalosporins <input type="checkbox"/> Penicillin <input type="checkbox"/> Others: _____ <input type="checkbox"/> Codeine <input type="checkbox"/> Quinolones		Health Conditions: <input type="checkbox"/> Arthritis <input type="checkbox"/> Glaucoma <input type="checkbox"/> None Known <input type="checkbox"/> Asthma <input type="checkbox"/> Heart Condition <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Others: _____	
Over-the-counter/Herbal medications taken regularly:			

Keep on file. Do not ship. If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them here:

Notes to Pharmacy:

<p>2 PHYSICIAN — Please fill out Section 2, or attach your office prescription to this form. Then FAX to 1-800-491-7997</p> <hr/> <p>Physician-Only Phone: 1-800-791-7658</p> <p>This document, including any attachments, contains personal and sensitive information related to a person's health care. The information contained in this document is intended only for the sole use of OptumRx. If you are not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the contents of this information is strictly prohibited and will be vigorously prosecuted.</p> <p>If you have received this document in error, please immediately notify the sender, or OptumRx by phone or fax at the numbers listed above.</p>	Patient Name	DOB
		
Refills <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Other: _____ Dispense as written <input type="checkbox"/> Yes		

Physician Name	Office Phone Number with Area Code	
Street Address	Fax Number with Area Code	
City, State, ZIP	NPI	DEA
Physician Signature	Date	

