

NEW PRESCRIPTION PHYSICIAN FAX ORDER FORM

Use this form to order a new mail service prescription by fax from the prescribing physician's office. Member completes section 1, while the physician completes sections 2 and 3. **This fax is void unless received directly from physician's office. To contact OptumRx, physicians may call 1-800-791-7658.**

1 Member information — to be completed by member

| | | | |
|--|---|--|-----------------------------|
| 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="radio"/> M <input type="radio"/> F | Email | |
| Medication Allergies: <input type="radio"/> Aspirin <input type="radio"/> Erythromycin <input type="radio"/> Quinolones <input type="radio"/> Others: _____ <input type="radio"/> None known <input type="radio"/> Cephalosporins <input type="radio"/> NSAIDs <input type="radio"/> Sulfa _____ <input type="radio"/> Amoxil/Ampicillin <input type="radio"/> Codeine <input type="radio"/> Penicillin <input type="radio"/> Tetracyclines _____ | | | |
| Health Conditions: <input type="radio"/> Asthma <input type="radio"/> Glaucoma <input type="radio"/> High cholesterol <input type="radio"/> Others: _____ <input type="radio"/> None known <input type="radio"/> Cancer <input type="radio"/> Heart condition <input type="radio"/> Osteoporosis _____ <input type="radio"/> Arthritis <input type="radio"/> Diabetes <input type="radio"/> High blood pressure <input type="radio"/> Thyroid Disease _____ | | | |
| Over-the-counter/herbal medications taken regularly: | | | |
| Keep on file. 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: | | | |

2 Physician and prescription information — physician to complete this section

| | | | |
|--|-----|---|-----|
| Prescribing Physician Name | | Patient Name | DOB |
| Physician Phone Number with Area Code | | <div style="font-size: 2em; font-weight: bold; margin-bottom: 10px;">Rx</div> <p><i>Enter prescription details here or attach your office prescription to the form.</i></p> | |
| Physician Fax Number with Area Code | | | |
| Physician Street Address | | | |
| City, State, ZIP | | | |
| NPI | DEA | | |
| <small>This document and others if attached contain information from OptumRx that is privileged, confidential and/or may contain protected health information (PHI). We are required to safeguard PHI by applicable law. The information in this document is for the sole use of the person(s) or company named above. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately and return the document(s) by mail to OptumRx Privacy Office, 17900 Von Karman, M/S CA016-0101, Irvine, CA 92614.</small> | | | |
| | | Refills: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> Other: _____ | |
| | | Dispense as written: <input type="radio"/> Yes | |
| | | X _____ Physician Signature | |
| | | _____ Date | |

3 Physician to fax completed order form to OptumRx at 1-800-491-7997.

