

Complete the following information and return to Prime Therapeutics Pharmacy LLC.
ePrescribers: Please note that we are a surescripts® network pharmacy.

Patient information <i>Please type or print clearly</i>	Name		DOB		<input type="checkbox"/> Male <input type="checkbox"/> Female	
	Street address				<input type="checkbox"/> Same address as last delivery	
	City			State		ZIP
	Home phone		Work		Cell	
	Email address					
Delivery information	Please note refrigerated medications are typically scheduled for delivery on Wednesday, Thursday or Friday.					
	Delivery date Your order will be delivered on the exact date indicated.					
	FedEx signature required	<input type="checkbox"/> Yes (Someone must be home to sign on the date you indicated above) <input type="checkbox"/> No (If no signature is selected, you are responsible for your medication)				
Prescription reorder information	Prescription Drug Name 1					
	Prescription Drug Name 2					
	Do you require any supply items?					
	Describe any changes in your medical condition or insurance since your last order					
	List all prescription, over-the-counter and herbal medications taken regularly: (use additional sheet if necessary)					
Payment information	Do you have a copay? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, amount of last copay \$	
	If your credit card is on file and you give permission to charge it, enter the last 4 digits: _____ We will only charge up to the amount of your last copay. If the amount is greater, we will contact you for permission.					
	<input type="checkbox"/> I consent to allow Prime Therapeutics Pharmacy to auto-enroll me in any patient assistance program.					
Certification	I certify that the above information is accurate to the best of my knowledge and further authorize processing of the prescription.					
	Signature				Date	

Generic equivalents are usually less expensive than brand-name drugs. If we dispense a brand-name drug, you may be responsible for a higher copay 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.**

Confidentiality notice: The information contained in this communication is confidential and intended for health care treatment. You are obligated to maintain it in a safe, secure and confidential manner. Redisclosure of this information is prohibited except as otherwise permitted by applicable law or appropriate consent. If you are not the intended recipient of this message, or the employee or agent responsible for delivery to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is strictly prohibited. If you have received this message in error, please notify the sender.

6870 Shadowridge Drive, Ste 111, Orlando, FL 32812 | Phone: 866.554.2673 | Fax: 866.364.2673