



Fax # 1-800-378-0323



PRESCRIBER SERVICES
New Prescription Request

FastStart® Fax Form

The following information is necessary in order to process your patient's prescription(s).
Using this fax form will expedite the prescription for the patient.

Please complete the 4 steps below.

Step 1 Patient Information

Patient Name: _____ DOB: _____

Address: _____ Phone: (____) _____ - _____

City, ST, ZIP: _____

CVS Caremark ID #: _____ Company: _____

Allergy Information: _____

Step 2 Prescription Information

<u>DRUG NAME</u>	<u>STRENGTH</u>	<u>DIRECTIONS</u>	<u>QUANTITY & REFILLS</u>
1. _____			90 Days or _____, 1 Year or _____
2. _____			90 Days or _____, 1 Year or _____
3. _____			90 Days or _____, 1 Year or _____
4. _____			90 Days or _____, 1 Year or _____

Prescriber Signature: _____

Faxed By: _____

Substitution Permissible – Unless Prescriber notes Brand Necessary or DAW on prescription
Note: Schedule II Controlled Substances cannot be submitted via fax.

Step 3 Physician Information Required

Dr. Name: _____ Phone: (____) _____ - _____

Address: _____ Fax: (____) _____ - _____

City, ST, ZIP: _____ DEA #: _____

Step 4 Fax information toll-free to 1-800-378-0323

If you are not the intended recipient of this FAX, you are hereby notified that any disclosure, copying or distributing is prohibited. If you have received this FAX in error or if you would like to talk to our staff, please notify us by phone toll-free at 1-800-378-5697. Plan participant privacy is important to us. Our employees are trained regarding the appropriate way to handle our plan participants' private health information.