

Mail your completed order form, original prescription(s) and payment to: **NextRx, PO Box 746000, Cincinnati, OH 45274-6000.**

If you have multiple prescriptions, include all prescriptions with the order form. You may duplicate the order form as needed.



**Section 1: Member Information**

Provide policy or cardholder information as found on the health plan or benefit card. Please do not write on the back of form.

<b>Name of Your Health Plan</b>		<b>Identification Number</b>		
[Redacted]		[Redacted]		
<b>Policy or cardholder last name</b>	<b>First name</b>	<b>Initial</b>	<b>Date of birth (MM/DD/YYYY)</b>	
[Redacted]	[Redacted]	[Redacted]	[Redacted] / [Redacted] / [Redacted]	

**Section 2: Shipping Information**

Orders ship within seven days of receipt of valid order. Controlled and refrigerated medications cannot ship to a PO box. Schedule II controlled substances require signature on delivery.

<b>New address</b>	<b>Street address</b>			<b>Apartment/suite</b>
<input type="checkbox"/> Y <input type="checkbox"/> N	[Redacted]		[Redacted]	
<b>City</b>	<b>State</b>	<b>ZIP code</b>	<b>Daytime phone # (including area code)</b>	
[Redacted]	[Redacted]	[Redacted]	[Redacted]	
<b>E-mail address</b>			<b>Evening phone # (including area code)</b>	
[Redacted]			[Redacted]	

**Section 3: Payment Information**

Payment is required before an order will ship. Do not send cash. Make checks and money orders payable to NextRx. There is a \$25 fee for returned checks. Credit cards are charged for the entire order and used for future orders unless a new payment method is specified. Rush shipping does not expedite prescription processing time.

<b>Payment method:</b>	<input type="checkbox"/> Check	<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> American Express	<input type="checkbox"/> Discover	<input type="checkbox"/> Overnight Shipping (add \$20)
<b>Account number</b>	<b>Expiration date</b>	<b>Signature/date</b>				
[Redacted]	[Redacted]	[Redacted]		[Redacted]		

Amount enclosed: [Redacted] Coupon Code: [Redacted]

Please place prescription(s) on file for later. Do not dispense at this time.

**Section 4: Prescription Information**

Federally approved, generic-equivalent medications will be dispensed for brand name medications unless otherwise directed by the patient, physician, or health plan.

<b>Patient last name</b>	<b>First name</b>	<b>Initial</b>	<b>Patient date of birth (MM/DD/YYYY)</b>	<b>Patient gender</b>
[Redacted]	[Redacted]	[Redacted]	[Redacted] / [Redacted] / [Redacted]	<input type="checkbox"/> M <input type="checkbox"/> F
<b>Drug allergies (check all that apply):</b> <input type="checkbox"/> Penicillin <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Sulfa				
<input type="checkbox"/> Other (list all, including over-the-counter medications) [Redacted]				
<b>Medical history (check all that apply):</b> <input type="checkbox"/> Diabetes <input type="checkbox"/> Glaucoma <input type="checkbox"/> High blood pressure <input type="checkbox"/> Arthritis				
<input type="checkbox"/> Thyroid <input type="checkbox"/> Heart condition <input type="checkbox"/> Asthma <input type="checkbox"/> Other (list all) [Redacted]				

<b>New prescription: medication name</b>	<b>Doctor last name</b>	<b>Taken before</b>	
[Redacted]	[Redacted]	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Check corresponding box to place prescription(s) on file for later fill. Do NOT dispense at this time.
[Redacted]	[Redacted]	<input type="checkbox"/> Y <input type="checkbox"/> N	
[Redacted]	[Redacted]	<input type="checkbox"/> Y <input type="checkbox"/> N	

<b>Refill orders: Rx refill #</b>	<b>Medication name</b>
[Redacted]	[Redacted]
[Redacted]	[Redacted]
[Redacted]	[Redacted]