



NEW PRESCRIPTION FAX FORM

Please complete the form and fax it to 951-955-0899. If you have any question, please call the Rubidoux Pharmacy at 1 (877) RIVCO-RX

Member ID # _____

Member Name _____
First Last Date of Birth

Ship To: _____
 Street name and apartment number City State Zip code

Medical Conditions: check if applies

Heart Attack or Failure ___
 High Blood Pressure ___
 Glaucoma___
 Asthma___
 Ulcer___
 Osteoporosis___

Allergies:

NONE ___ List if any_____

Lab if available:

BP___ LDL___ HDL___ Cholesterol___
 Glucose___ Fasting___ BUN___ Creat___

Prescriber Name _____		Date ___/___/___	
Prescriber Tele. # _____		Prescriber Fax # _____	
Patient Name: _____		_____	
FIRST		LAST	
Address: _____		_____	
Street Name and Number		City	State Zip code
Rx		Refills_____	

Prescriber Signature – Substitution Permissible			

Prescriber Signature – Dispense as written			

NO CII will be accepted via fax. Most patients can receive up-to 90 days supply.