



7034 Alamo Downs Parkway  
San Antonio, TX. 78238

Prescription Service Division

## NewRx Request

The following information is necessary in order to process your patients prescription(s). **Please complete the 5 areas below.**

<b>AREA 1</b>		<b>Patient Information</b>		
Patient Name: _____		Member ID#: _____		
Address: _____		Phone: (____) _____ - _____		
City, ST, Zip: _____		DOB: ____/____/____		
Allergy Info: _____		Company _____		
<b>AREA 2</b>		<b>Prescriptions</b>		
Date _____		<input type="checkbox"/> Please check this box if this is a request for a controlled substance		
DRUG NAME	STR	DIRECTIONS	QTY	REF
1. _____				
2. _____				
3. _____				
4. _____				
Comments: _____				
<b>AREA 3</b>		<b>Physician Signature Required</b>		
Dr. _____		Dr. _____		
DISPENSE AS WRITTEN		PRODUCT SELECTION PERMITTED		
* If the above signature is from a PAC or RNP, please supply the following information				
* _____		_____	_____	
Print PAC/RNP Name		License #	Print Supervising Physician	
<b>AREA 4</b>		<b>Physician Information Required</b>		
Dr.'s Name: _____		Phone : (____) _____ - _____		
Address: _____		Fax : (____) _____ - _____		
City/ ST/Zip: _____		DEA # _____		
<b>AREA 5</b>		<b>Fax Information</b>		
Faxed by: _____		<b>1-800-378-0323</b>		<b>Caremark</b>
(Full Name if other than physician)				