Print Form

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

DRUG NAME	STRENGTH	DIRECTIONS	QUANTITY & REFILLS
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