



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

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
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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.