

Member ID Number					Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Last Name			First Name			MI
Delivery Address					Apt. #	
City		State	Zip Code		Phone Number (list in order of preference)	
Date of Birth / /		Email Address			<div>(circle one)</div> <div>() M H W</div> <div>() M H W</div> <div>() M H W</div>	
Physician Name		Physician Phone Number ()				

Medication Allergies:			Health Conditions:		
<input type="checkbox"/> Amoxil/Ampicillin	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> None Known	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> None Known
<input type="checkbox"/> Aspirin	<input type="checkbox"/> NSAIDs	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Tetracyclines	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Codeine	<input type="checkbox"/> Quinolones	<input type="checkbox"/> Others: _____	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Others: _____

List all prescription, over-the-counter and herbal medications taken regularly: (use additional sheet if necessary)

1: _____ 2: _____ 3: _____ 4: _____
5: _____ 6: _____ 7: _____ 8: _____

Generic substitution: FDA-approved generic equivalents will be dispensed for brand-name drugs whenever possible, unless you or your physician indicate otherwise. Brand-name medications may be subject to a higher cost. Generic equivalents are usually less expensive than brand name drugs. If we dispense a brand name drug, you may be responsible for a higher copayment and/or the difference between the brand and generic price of each drug. If allowed by your prescriber, we will dispense a generic equivalent unless you check this box. ☐ I do not accept a generic equivalent.

Keep on file: If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them here:

Notes to Pharmacy:

Standard delivery is included at no charge. Most prescription orders arrive within 7-10 days from the date your order is received. We will contact you if there is an extended delay in delivering your medications. Please call 800-424-8274 (TTY: 711) if you have any questions. Once shipped, medications may not be returned for a refund or adjustment.

- ☐ Ship overnight (additional charges will apply). Please call to verify pricing. No P.O. BOX overnight shipping.
- ☐ Check enclosed. All checks must be signed and made payable to Magellan Rx Pharmacy.
- ☐ Charge to my NEW credit card.
- ☐ Charge to my credit card on file.

I authorize Magellan Rx Pharmacy to charge the following amount to my credit/debit card without prior notification:

_____ up to \$150 _____ up to \$250 _____ up to \$_____ (other amount greater than \$250)

For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance, and other such expenses related to prescription orders. By supplying my credit card number, I authorize Magellan Rx Pharmacy to maintain my credit card on file as payment method for any future charges. To modify payment selection, Customer Service can be contacted at any time at 800-424-8274 (TTY: 711).

Cardholder Signature:	Date:
Credit card number (VISA®, MasterCard®, Discover®, or American Express® are accepted) and expiration date (month/year)	
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Mail this completed order form with your new prescription(s) to Magellan Rx Pharmacy, P.O. Box 620968, Orlando, FL 32862. DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.