

Mail your completed order form, original prescription(s) and payment to: NextRx, PO Box 746000, Cincinnati, OH 45274-6000.
 If you have multiple prescriptions, include all prescriptions with the order form. You may duplicate the order form as needed.

SECTION 1: MEMBER INFORMATION

Provide policy or cardholder information as found on the health plan or benefit card. Please do not write on the back of form.

Name of Your Health Plan		Identification Number	
<input type="text"/>		<input type="text"/>	
Policy or cardholder last name	First name	Initial	Date of birth (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SECTION 2: SHIPPING INFORMATION

Orders ship within seven days of receipt of valid order. Controlled and refrigerated medications cannot ship to a PO box. Schedule II controlled substances require signature on delivery.

New address	Permanent address	Street address	Apartment/suite
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/>	<input type="text"/>
City	State	ZIP code	Daytime phone # (including area code)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E-mail address	Evening phone # (including area code)		
<input type="text"/>	<input type="text"/>		

SECTION 3: PAYMENT INFORMATION

Payment is required before an order will ship. Do not send cash. Make checks and money orders payable to NextRx. There is a \$25 fee for returned checks. Credit cards are charged for the entire order and used for future orders unless a new payment method is specified. Overnight shipping does not expedite prescription processing time.

Payment method: Check Visa MasterCard American Express Discover Overnight Shipping (add \$20)

Account number	Expiration date	Signature/date
<input type="text"/>	<input type="text"/>	<input type="text"/>

Amount enclosed: **Coupon Code:**

SECTION 4: PRESCRIPTION INFORMATION

Federally approved, generic-equivalent medications will be dispensed for brand name medications unless otherwise directed by the patient, physician, or health plan. If you require brand medications, please use the comments section below and list the names of the medications. Brand may be subject to higher cost.

Patient last name	First name	Initial	Patient date of birth (MM/DD/YYYY)	Patient gender
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F

Drug allergies (check all that apply): Penicillin Aspirin Codeine Sulfa
 Other (list all, including over-the-counter medications)

Medical history (check all that apply): Diabetes Glaucoma High blood pressure Arthritis
 Thyroid Heart condition Asthma Other (list all)

New prescription: medication name	Doctor last name	Taken before	PLACE ON PROFILE
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> (will order when needed)
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>

Refill orders: Rx refill #	Medication name	Refill orders: Rx refill #	Medication name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Comments