Physician Prescription Fax Form

Fax number: 801-595-4440

UPREHS Depot Drug Mail Order Pharmacy
PO Box 161020
Salt Lake City, UT 84116-1020
Customer Services: 1-800-547-0421

Physicians, please fax this completed form along with your written prescriptions directly from your office. We cannot accept faxed prescriptions from members. Members may use this form to mail their prescriptions, but NOT to fax.

Physician Name _____ Phone (____) _____

Fax (____)_____ DEA# _____ NPI# _____

Member Name _____ Phone (____) _____

UPREHS ID Card # _____ Medicare #_____

We will mail the prescription to the member's address on our file. Complete below if a different address is required.

Street Address _____

City, State, Zip _____

Copayments must be made at the time of order for the prescription(s) to be shipped. Copayments can be made with either a Visa or MasterCard.

☐ Use the credit card already on file.

☐ Use the following Visa or MasterCard

Credit Card Number Expiration Date

																XXX				

Circle number of months to be filled at this time: 1 (one month) 2 (two months) 3 (three months)

NOTE: UPREHS Depot Drug Mail Order Pharmacy will provide FDA-approved generic medications whenever possible, unless the physician indicates that a generic drug may not be substituted for a name brand medication. Copayments are much higher for name brand drugs.

Please allow 10 business days to receive your prescription.

Member Signature_____ Date _____

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