

Placing an Order for New Prescriptions:

Fill out profile form and mail in original prescriptions

OR

Log onto www.drugsourceinc.com to complete an online patient profile and request us to contact your doctor for your prescriptions by filling out an Obtain a New Prescription form

Helpful tips on Prescriptions

The diagram shows a prescription form with the following fields and callouts:

- DEA# GD00000000**
- Dr. John Doe** (Callout: Circle your Doctor's name)
- 123 Anywhere Rd**
- Any City, State 12345**
- Name** (Callout: Clearly written patient name and date of birth)
- Age**
- Address**
- Date**
- Rx** (Callout: Ask doctor to prescribe a 90-day supply)
- Medication Name & Strength**
- Directions**
- Quantity or 90-day supply**
- Dispense as Written**
- Substitution Permissible**
- Refills 1 2 3 4 5 PRN**

- Mail **original** prescriptions with completed form
- Include **patient name** and **date of birth** on the back of each prescription
- Discuss **generic** medication with your doctor. DrugSource will fill your order with the generic medication, if one is available, if both you and your doctor agree to generic substitution
- New prescriptions may only be **faxed** from **your doctor**
- Pharmacist available **24/7** for consultation

Payment

DrugSource, Inc. accepts:

VISA MASTERCARD DISCOVER AMER. EXP
PERSONAL CHECK MONEY ORDER

Please Note: According to Illinois State Law, if you are using a Schedule II narcotic such as Ritalin, Adderall, Concerta, Duragesic patches, etc., you need to submit a written prescription to us within seven (7) days from the date written on the prescription. Some states don't allow an out of state pharmacy to fill Schedule II prescriptions or some may restrict quantities.

New Patient Information – Fill in All Shaded Areas

Refills/Payment Information – Turn to 2nd Side

Company Name	Group Number*
I.D. Number*	Bin Number*

*Located on your insurance card

Cardholder's Name (Please Print) _____

First

Middle

Last

Address _____ Phone _____

Street

Apt#

City

State

Zip Code

Day Phone _____

Shipping Address, if different _____

Cardholder's Date of Birth ____/____/____ Male Female Are you pregnant at this time? Yes No

Describe Cardholder's drug allergies and medical conditions: _____ Check here if none:

Print Name of Physician ordering medication: _____

Physician Phone Number _____ Physician Fax _____

EMAIL ADDRESS FOR SHIPPING CONFIRMATION _____

If an eligible dependent in your family has any drug allergies, medical conditions, is sensitive to any drugs, or is pregnant, list below. **If you have no eligible dependents, check here --**

Spouse

Name _____ Female Male

Drug Allergies _____ Date of Birth ____/____/____

Medical Condition _____ Doctor's Name _____

Dependents

Name _____ Female Male

Drug Allergies _____ Date of Birth ____/____/____

Medical Condition _____ Doctor's Name _____

Name _____ Female Male

Drug Allergies _____ Date of Birth ____/____/____

Medical Condition _____ Doctor's Name _____

Name _____ Female Male

Drug Allergies _____ Date of Birth ____/____/____

Medical Condition _____ Doctor's Name _____

I authorize DrugSource to dispense generic medication. Yes No
I understand that refusal of generic medications may impact my co-payment.
Would you like a call from a Pharmacist to discuss any medical questions that you may have? Yes No