



PRESCRIPTION AUTHORIZATION FAX FORM

Pharmacy (toll free) Fax # 844-922-7379
(for veterinary use only)

CareFirst Veterinary Pharmacy

400 Fellowship Road, Suite 100

Mount Laurel, NJ 08054

Office: 856-267-0528 / Toll Free: 844-822-7379

Fax: 800-786-1405 or 844-922-7379

e-mail: fax@cfspharmacy.com

www.cfspharmacy.com

Dear Pet Owner,

Thank you for choosing CareFirst Veterinary Pharmacy.

To order a prescription medication, a prescription from a US-licensed veterinarian is required. For your convenience, and for the convenience of your veterinarian, please feel free to utilize the following form. Please print this PDF document and fill out your contact information.

IMPORTANT: Deliver the fax form to your veterinarian for further processing.
State and Federal pharmacy laws stipulate that pet prescriptions may only be faxed to a licensed pharmacy from a US-licensed veterinarian.

PET OWNER

Step 1: You can call us to setup a new account for your pet or proceed to Step 2.

Step 2: PRINT Veterinary Rx Authorization FAX Form & fill in your contact info under Section A - Pet Owner

Step 3: BRING this to your veterinarian for authorization. (We cannot accept any prescriptions unless faxed from a veterinarian).

VETERINARIAN

Step 4: COMPLETE FORM

Step 5: FAX to CareFirst Veterinary Pharmacy to 1-800-786-1405 or if you prefer you may call in the prescription verbally over the phone at 1-844-822-7379

Ordering from CareFirst is easy once we get your pet's prescription on file. If you have any questions, or wish to place your order by phone, feel free to call us any time at 844-822-7379.

Thank You,
CareFirst Pharmacy Staff

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VETERINARY PRESCRIPTION AUTHORIZATION FAX FORM

Pharmacy (toll free) Fax

844-922-7379

(for veterinary use only)

ATTENTION VETERINARIAN: Thank you for choosing CareFirst to fill a prescription for your client's medication(s). If you have any questions, please call 844-822-7379.

SECTION A: PET OWNER – please print information below

OWNER	First Name _____	Last Name _____	Customer Number – (optional) _____	PET'S NAME _____
BILLING ADDRESS	Address _____			SHIPPING ADDRESS (if different) _____
	City _____	State _____	Zip _____	PREFERRED SHIPPING METHOD
PHONE _____	EMAIL _____			<input type="checkbox"/> Ground <input type="checkbox"/> Second Day Air <input type="checkbox"/> Overnight

SECTION B: VETERINARIAN – please print prescription info (or attach RX below) and fax to 844-922-7379

***** This Area for Veterinary Use Only *****

VETERINARIAN	First Name _____	Last Name _____	State License # _____	DEA # (for controls) _____						
CLINIC	Office Name _____			<table><tr><td>Bill to</td><td>Ship to</td></tr><tr><td><input type="checkbox"/> Office</td><td><input type="checkbox"/> Office</td></tr><tr><td><input type="checkbox"/> Patient</td><td><input type="checkbox"/> Patient</td></tr></table>	Bill to	Ship to	<input type="checkbox"/> Office	<input type="checkbox"/> Office	<input type="checkbox"/> Patient	<input type="checkbox"/> Patient
Bill to	Ship to									
<input type="checkbox"/> Office	<input type="checkbox"/> Office									
<input type="checkbox"/> Patient	<input type="checkbox"/> Patient									
	City _____	State _____	Zip _____							
PHONE _____	FAX _____			Email _____						

1	Pet's Name	Species	Weight	Sex	Age/DOB	
	Compounded Medication					
	Strength	Dosage Form	QTY per item	Number of item	Add'l # of Refills	Other
	Directions for Use:					
2	Pet's Name	Species	Weight	Sex	Age/DOB	
	Compounded Medication					
	Strength	Dosage Form	QTY per item	Number of item	Add'l # of Refills	Other
	Directions for Use:					

Please indicate any known allergies/medical conditions: _____

Please list any additional medication that the patient is taking: _____

Veterinarian's Signature

(Please review directions and number of refills)

Name

Date

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