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

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 _____

☐ Ground ☐ Second Day Air ☐ 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)

_____ (City / State / Zip)

PHONE _____ FAX _____ Email _____

Bill to	Ship to
☐ Office	☐ Office
☐ Patient	☐ Patient

1	**Pet's Name**		**Species**	**Weight**	**Sex**	**Age/DOB**
	Compounded Medication					
	Strength	**Dosage Form**	**QTY per item**	**Number of item**	**Addt'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**	**Addt'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 Name Date

(Please review directions and number of refills)