

Please read the information below and complete the pages that apply to the format you are ordering.

For the following NJPB Exemplars, please complete **Page 2** or, if submitting a Group Practice Order, **Pages 2 and 3**

MD
DO
DDS/DMD
DPM
DVM/VMD/BVSc
OPTOMETRIST

For the following NJPB Exemplars, please complete **Page 4:**

ADVANCED PRACTICE NURSE
CERTIFIED NURSE MIDWIFE
PHYSICIAN ASSISTANT

For the following NJPB Exemplar, please complete **Page 5:**
FACILITIES



Please print and complete this form, and fax to: 1-877-RXPADS1 (1-877-797-2371)

Phone: 1-800-969-7237 • P.O. Box 1149, Morrisville, PA 19067-9149 • www.TripleiRxPads.com

CONTACT

Name: Phone: - - Email*:

*Your email address will be used to aid us in processing orders from you and will not be shared.

BILLING

Method of Payment: ☐ Check Enclosed (make check payable to Triple i) ☐ Visa ☐ Master Card ☐ American ExpressCredit Card Number: Exp: / Name on Card: Cardholder's Signature: Date:

IMPRINT INFORMATION

Practice Name: 1. Practitioner Name: Professional Designation: License Number: NPI Number: ☒ here to print DEA Number: ☒ here to print 1. Building: Address Line 1: Address Line 2: City: State: Zip: Email*: Phone: - - Fax: - -

*Your email address will not print on your prescription pad and will not be shared.

Signature (Mandatory): Date:

For Group Practice orders, the Practitioner in this section is the Designated Recipient

Also fax a voided script for sample of imprint content. Indicate changes to practice information on voided script.

To purchase separate pads for individual practice locations, please submit one order form for each location.

PRICING

☐ 1-PART PADS (100 Scripts per Pad)☐ 2-PART PADS (50 Scripts per Pad w/Carbonless Duplicate)

New Jersey Pad Type	8 Pads	16 Pads	24 Pads	32 Pads	40 Pads	48 Pads	72 Pads	8 Pads	16 Pads	24 Pads	32 Pads	40 Pads	48 Pads	72 Pads
MD, DO, DDS/DMD, DPM, DVM/VMD/BVSc	<input type="checkbox"/> \$75.40	<input type="checkbox"/> \$100.40	<input type="checkbox"/> \$135.40	<input type="checkbox"/> \$165.40	<input type="checkbox"/> \$195.40	<input type="checkbox"/> \$225.40	<input type="checkbox"/> \$335.40	<input type="checkbox"/> \$110.40	<input type="checkbox"/> \$130.40	<input type="checkbox"/> \$180.40	<input type="checkbox"/> \$250.40	<input type="checkbox"/> \$320.40	<input type="checkbox"/> \$375.40	<input type="checkbox"/> \$520.40
Optometry - Eyewear*	<input type="checkbox"/> \$75.40	<input type="checkbox"/> \$100.40	<input type="checkbox"/> \$135.40	<input type="checkbox"/> \$165.40	<input type="checkbox"/> \$195.40	<input type="checkbox"/> \$225.40	<input type="checkbox"/> \$335.40	<input type="checkbox"/> \$110.40	<input type="checkbox"/> \$130.40	<input type="checkbox"/> \$180.40	<input type="checkbox"/> \$250.40	<input type="checkbox"/> \$320.40	<input type="checkbox"/> \$375.40	<input type="checkbox"/> \$652.40
Optometry - Blank*	<input type="checkbox"/> \$75.40	<input type="checkbox"/> \$100.40	<input type="checkbox"/> \$135.40	<input type="checkbox"/> \$165.40	<input type="checkbox"/> \$195.40	<input type="checkbox"/> \$225.40	<input type="checkbox"/> \$335.40	<input type="checkbox"/> \$110.40	<input type="checkbox"/> \$130.40	<input type="checkbox"/> \$180.40	<input type="checkbox"/> \$250.40	<input type="checkbox"/> \$320.40	<input type="checkbox"/> \$375.40	<input type="checkbox"/> \$652.40
UPS Ground Shipping (Secure Signature Required)	\$10.50	\$10.50	\$10.50	\$12.50	\$12.50	\$12.50	\$14.50	\$10.50	\$10.50	\$10.50	\$12.50	\$12.50	\$12.50	\$14.50
Order Total														

Call for Expedited Shipping Charges

* TPA/OM Certification Number Required for Optometry NJPBs

SHIPPING

Shipping Address (If different from Imprint 1):

Note: Must match address on file with the NJ Division of Consumer Affairs. For Group Orders, please provide Designated Recipient's DCA address.

Attn: Building: Address Line 1: Address Line 2: City: State: Zip: Phone: - -



Please print and complete this form, and fax to: 1-877-RXPADS1 (1-877-797-2371)

Phone: 1-800-969-7237 • P.O. Box 1149, Morrisville, PA 19067-9149 • www.TripleiRxPads.com

Contact Name:

Practice Name:

**NOTE: When printing multiple practitioners, you may also fax a voided script for our reference.
For NJPB Group Practice Orders, the Designated Recipient is Practitioner 1 (Imprint Information).**

List information for additional practitioners that are to print on pad below. For practices with more than 8 practitioner names, please call the Triple i Customer Service Center at 1-800-969-7237 to place your order.

ADDITIONAL PRESCRIBER & IMPRINT INFORMATION

2. Practitioner Name: Professional Designation:

License Number:

NPI Number:

✓ here to print

DEA Number:

✓ here to print

TPA/OM Certification Number*:

Signature (Mandatory):

Date:

3. Practitioner Name: Professional Designation:

License Number:

NPI Number:

✓ here to print

DEA Number:

✓ here to print

TPA/OM Certification Number*:

Signature (Mandatory):

Date:

4. Practitioner Name: Professional Designation:

License Number:

NPI Number:

✓ here to print

DEA Number:

✓ here to print

TPA/OM Certification Number*:

Signature (Mandatory):

Date:

5. Practitioner Name: Professional Designation:

License Number:

NPI Number:

✓ here to print

DEA Number:

✓ here to print

TPA/OM Certification Number*:

Signature (Mandatory):

Date:

6. Practitioner Name: Professional Designation:

License Number:

NPI Number:

✓ here to print

DEA Number:

✓ here to print

TPA/OM Certification Number*:

Signature (Mandatory):

Date:

7. Practitioner Name: Professional Designation:

License Number:

NPI Number:

✓ here to print

DEA Number:

✓ here to print

TPA/OM Certification Number*:

Signature (Mandatory):

Date:

8. Practitioner Name: Professional Designation:

License Number:

NPI Number:

✓ here to print

DEA Number:

✓ here to print

TPA/OM Certification Number*:

Signature (Mandatory):

Date:

*Optometrists must provide their TPA or OM Certification Number if ordering Eyewear/Blank or Blank scripts.

TripleiRxPads.com

Questions? Please call: 1-800-969-7237



CONTACT

Name: Phone: - -
Email*:

*Your email address will be used to aid us in processing orders from you and will not be shared.

BILLING

Method of Payment: ☐ Check Enclosed (make check payable to Triple i) ☐ Visa ☐ Master Card ☐ American Express
Credit Card Number: Exp: /
Name on Card:
Cardholder's Signature: Date:

IMPRINT INFORMATION

Practice Name:
1. Practitioner Name: Professional Designation:
APN Certification Number: CNM Rx Authorization Number: PA License Number:
NPI Number: ☒ here to print ☐ DEA Number: ☒ here to print ☐
1. Building:
Address Line 1:
Address Line 2:
City: State: Zip:
Email*: Phone: - - Fax: - -
*Your email address will not print on your prescription pad and will not be shared.
Signature (Mandatory): Date:

Also fax a voided script for sample of imprint content. Indicate changes to practice information on voided script.

To purchase separate pads for individual practice locations, please submit one order form for each location.

Note: Supervising Physician information is required for PA orders. The Collaborative Physician Information is optional for APN and CNM orders. If not provided, blank labeled lines will print on the script.

Supervising/Collaborative Physician Name:
Supervising/Collaborative Physician License Number:
Supervising/Collaborative Physician Phone: - -

PRICING

New Jersey Pad Type	<input type="checkbox"/> 1-PART PADS (100 Scripts per Pad)							<input type="checkbox"/> 2-PART PADS (50 Scripts per Pad w/Carbonless Duplicate)						
	8 Pads	16 Pads	24 Pads	32 Pads	40 Pads	48 Pads	72 Pads	8 Pads	16 Pads	24 Pads	32 Pads	40 Pads	48 Pads	72 Pads
Advanced Practice Nurse	<input type="checkbox"/> \$75.40	<input type="checkbox"/> \$100.40	<input type="checkbox"/> \$135.40	<input type="checkbox"/> \$165.40	<input type="checkbox"/> \$195.40	<input type="checkbox"/> \$225.40	<input type="checkbox"/> \$335.40	<input type="checkbox"/> \$110.40	<input type="checkbox"/> \$130.40	<input type="checkbox"/> \$180.40	<input type="checkbox"/> \$250.40	<input type="checkbox"/> \$320.40	<input type="checkbox"/> \$375.40	<input type="checkbox"/> \$520.40
Certified Nurse Midwife	<input type="checkbox"/> \$75.40	<input type="checkbox"/> \$100.40	<input type="checkbox"/> \$135.40	<input type="checkbox"/> \$165.40	<input type="checkbox"/> \$195.40	<input type="checkbox"/> \$225.40	<input type="checkbox"/> \$335.40	<input type="checkbox"/> \$110.40	<input type="checkbox"/> \$130.40	<input type="checkbox"/> \$180.40	<input type="checkbox"/> \$250.40	<input type="checkbox"/> \$320.40	<input type="checkbox"/> \$375.40	<input type="checkbox"/> \$652.40
Physician Assistant	<input type="checkbox"/> \$75.40	<input type="checkbox"/> \$100.40	<input type="checkbox"/> \$135.40	<input type="checkbox"/> \$165.40	<input type="checkbox"/> \$195.40	<input type="checkbox"/> \$225.40	<input type="checkbox"/> \$335.40	<input type="checkbox"/> \$110.40	<input type="checkbox"/> \$130.40	<input type="checkbox"/> \$180.40	<input type="checkbox"/> \$250.40	<input type="checkbox"/> \$320.40	<input type="checkbox"/> \$375.40	<input type="checkbox"/> \$652.40
UPS Ground Shipping (Secure Signature Required)	\$10.50	\$10.50	\$10.50	\$12.50	\$12.50	\$12.50	\$14.50	\$10.50	\$10.50	\$10.50	\$12.50	\$12.50	\$12.50	\$14.50
Order Total														

Call for Expedited Shipping Charges

SHIPPING

Shipping Address (If different from Imprint 1): **Note:** Must match address on file with the NJ Division of Consumer Affairs.
Attn:
Building:
Address Line 1:
Address Line 2:
City: State: Zip: Phone: - -

CONTACT

Name: Phone: - - Email*:

*Your email address will be used to aid us in processing orders from you and will not be shared.

BILLING

Method of Payment: ☐ Check Enclosed (make check payable to Triple i) ☐ Visa ☐ Master Card ☐ American ExpressCredit Card Number: Exp: / Name on Card: Cardholder's Signature: Date:

IMPRINT INFORMATION

Institution/Facility Name: Facility Provider Number: 1. Ordering Practitioner's Name: Professional Designation: License Number: 1. Building: Address Line 1: Address Line 2: City: State: Zip: Email*: Phone: - - Fax: - -

*Your email address will not print on your prescription pad and will not be shared.

Signature of Requesting Practitioner (Mandatory): Date:

Also fax a voided script for sample of imprint content. Indicate changes to facility information on voided script.

To purchase separate pads for individual practice locations, please submit one order form for each location.

PRICING

☐ 1-PART PADS (100 Scripts per Pad)☐ 2-PART PADS (50 Scripts per Pad w/Carbonless Duplicate)

New Jersey Pad Type	8 Pads	16 Pads	24 Pads	32 Pads	40 Pads	48 Pads	72 Pads	8 Pads	16 Pads	24 Pads	32 Pads	40 Pads	48 Pads	72 Pads
NJPB - Facilities	<input type="checkbox"/> \$75.40	<input type="checkbox"/> \$100.40	<input type="checkbox"/> \$135.40	<input type="checkbox"/> \$165.40	<input type="checkbox"/> \$195.40	<input type="checkbox"/> \$225.40	<input type="checkbox"/> \$335.40	<input type="checkbox"/> \$110.40	<input type="checkbox"/> \$130.40	<input type="checkbox"/> \$180.40	<input type="checkbox"/> \$250.40	<input type="checkbox"/> \$320.40	<input type="checkbox"/> \$375.40	<input type="checkbox"/> \$520.40
UPS Ground Shipping (Secure Signature Required)	\$10.50	\$10.50	\$10.50	\$12.50	\$12.50	\$12.50	\$14.50	\$10.50	\$10.50	\$10.50	\$12.50	\$12.50	\$12.50	\$14.50
Order Total														

Call for Expedited Shipping Charges

SHIPPING

Shipping Address (If different from Imprint 1):**Note:** Must match address on file with the NJ Division of Consumer Affairs.Attn: Building: Address Line 1: Address Line 2: City: State: Zip: Phone: - -