CVS CAREMARK | Mail Service Pharmacy

Fax # 1-800-378-0323

FastStart® New Prescription Fax Form

If you would like to send a maintenance prescription to CVS Caremark Mail Service Pharmacy for your patient, please complete this form and fax it to the number above.

Please complete the 4 steps below.

Step 1: Patient Information

Patient Name: _____ DOB: _____

Address: _____ Phone: (_____) _____ - _____

City, ST, ZIP: _____

CVS Caremark Member ID#: _____ Prescription Benefit Provider _____

Allergy Information: _____

Step 2: Prescription Information

Prescription Date: _____

DRUG NAME	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
1. _____	_____	_____	90 days or _____	1 year or _____
2. _____	_____	_____	90 days or _____	1 year or _____
3. _____	_____	_____	90 days or _____	1 year or _____
4. _____	_____	_____	90 days or _____	1 year or _____

_____ **Authorized by/Title:** _____

(Prescriber Signature) (Full name if other than physician)

Substitution permissible unless prescriber writes brand necessary or DAW

Step 3: Physician Information Required

Dr. Name: _____ **Phone: (_____) _____ - _____**

Address: _____ **Fax: (_____) _____ - _____**

City, ST, ZIP: _____

NPI #: _____ **DEA #** (If controlled substance)**:** _____

Step 4: Fax this form toll-free to 1-800-378-0323