



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 _____

(Prescriber Signature) Authorized by/Title: _____
(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

If you are not the intended recipient of this FAX, you are hereby notified that any disclosure, copying or distributing is prohibited. If you have received this FAX in error or if you would like to talk to our staff, please notify us by phone toll-free at 1-800-378-5697. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle our members' private health information.