

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 Info	rmation			
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 I	nformation Re	quired		
Dr. Name: Phone: ()				
Address: Fax: ()				
City, ST, ZIP:				
	DEA # (If controlled substance):			
		•		

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.

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