SECURE TAMPER RESISTANT ORDER FORM

Please Print Clearly

Distributor Name _____ Account # _____

Address _____ Phone # _____

Contact _____ Fax # _____

City _____ ST _____ ZIP _____ PO# _____

Prescriber Information (As you want it to appear on the form) *Required Field

Clinic or Business Name _____

*Prescriber Name _____

Specialty _____

*Address _____ Ste: _____

*City _____ *State _____ Zip _____

*Phone # _____ *License# _____ DEA # _____
(If State Required, Include DEA #)

Fax # _____ Starting # _____

Total # of Prescribers_____ Total # of Addresses_____ (Enter Additional Prescribers on Page 2)

Ship To _____

_____

_____

_____

Ship Method

☐ FedEx Ground ☐ FedEx Priority Overnight

☐ FedEx 2nd Day ☐ FedEx Express Saver

☐ Other _____

1 Part Pads (100 sheets per pad)
☐ 4-1/4”w X 5-1/2”h (Vertical)
☐ 5-1/2”w X 4-1/4”h (Horizontal)
Quantity:
☐ 4 pads
☐ 8 pads
☐ 12 pads
☐ 16 pads
☐ 20 pads
☐ 40 pads
☐ 60 pads
☐ 80 pads

2 Part Sets (50 sets per pack)
☐ 4-1/4”w X 5-1/2”h (Vertical)
☐ 5-1/2”w X 4-1/4”h (Horizontal)
Quantity:
☐ 4 packs
☐ 8 packs
☐ 12 packs
☐ 16 packs
☐ 20 packs
☐ 40 packs
☐ 60 packs
☐ 80 packs

Cut Sheets (100 sheets per set)
☐ 8 1/2”x 11” (1 script per sheet)
Quantity:
☐ 4 sets
☐ 8 sets
☐ 12 sets
☐ 16 sets
☐ 20 sets
☐ 40 sets
☐ 60 sets
☐ 80 sets

Leadtime: 3-5 Days after order approval

Valid for Medicaid Prescriptions in the following states: AL, AK, AZ, AR, CO, CT, GA, HI, ID, IL,IA, KS, LA, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WI

NOT Valid for Medicaid Prescriptions in the following states: CA, DE, FL, IN, KY, ME, NJ, NY, WA, WV, WY

ADDITIONAL PRESCRIBERS Please print Clearly

Prescriber Information (As you want it to appear on the form) *Required Field

Clinic or Business Name ______________________________
*Prescriber Name ______________________________
Specialty ______________________________
*Address ______________________________ Ste: ______________
*City ______________________________ *State ________ Zip ______________
*Phone # ______________ *License# ______________ DEA # ______________
Fax # ______________ Starting # ______________ (If State Required, Include DEA #)

Clinic or Business Name ______________________________
*Prescriber Name ______________________________
Specialty ______________________________
*Address ______________________________ Ste: ______________
*City ______________________________ *State ________ Zip ______________
*Phone # ______________ *License# ______________ DEA # ______________
Fax # ______________ Starting # ______________ (If State Required, Include DEA #)

Clinic or Business Name ______________________________
*Prescriber Name ______________________________
Specialty ______________________________
*Address ______________________________ Ste: ______________
*City ______________________________ *State ________ Zip ______________
*Phone # ______________ *License# ______________ DEA # ______________
Fax # ______________ Starting # ______________ (If State Required, Include DEA #)

Clinic or Business Name ______________________________
*Prescriber Name ______________________________
Specialty ______________________________
*Address ______________________________ Ste: ______________
*City ______________________________ *State ________ Zip ______________
*Phone # ______________ *License# ______________ DEA # ______________
Fax # ______________ Starting # ______________ (If State Required, Include DEA #)

Clinic or Business Name ______________________________
*Prescriber Name ______________________________
Specialty ______________________________
*Address ______________________________ Ste: ______________
*City ______________________________ *State ________ Zip ______________
*Phone # ______________ *License# ______________ DEA # ______________
Fax # ______________ Starting # ______________ (If State Required, Include DEA #)