Innoviant® Pharmacy

PO BOX 400
Hatboro, PA 19040-9971

Phone: 877-390-9200

Fax: 866-479-3297

Dear Physician:

Please use this form to fax new prescriptions to Innoviant Pharmacy for patients that have enrolled in our mail order pharmacy service. A separate form for refills of previously prescribed medication is available from patient.

Patient Last	Patient First	DOB	Member ID

Prescribing Physician

Last Name **First Name** **DEA#**

Street Address **City** **State** **ZIP**

( ) **( )**

Phone **Fax**

Medication: _____

Quantity: _____

SIG: _____

Refills: 0 1 2 3 PRN **Generic Substitution? Y N**

Medication: _____

Quantity: _____

SIG: _____

Refills: 0 1 2 3 PRN **Generic Substitution? Y N**

_____ **Signature of Prescriber**

_____/_____/_____ **Date**