PRESCRIPTION ORDER FORM

Please fill out the following form and fax to the Affinity Pharmacy of your choice.

Last Name: ____________________ First Name: ____________________ M. Initial: ________

Date of Birth: ____________________ Member ID Number: ____________________

Mailing Address: ____

City: ____________________ State: ____________________ Zip Code: ____________

Home Number: ______________ Cell Number: ______________ Other: ______________

Email Address: ______________________________ SSN: ______________

Allergies: ____

PRESCRIPTION INFORMATION

Please check the box to indicate how you prefer to receive your prescriptions.

Transfer and mail my prescriptions using my credit/debit card to pay any and all charges

Transfer my prescriptions and I will pick up at the retail location I've selected below:

Affinity Pharmacy at Saint John (APS)   Affinity Pharmacy at Oliver Road (APO)

See back for contact information for each Affinity Pharmacy, as well as an informational chart to help select which option better takes care of your prescription needs. You can call the Affinity Pharmacy of your choice with your prescription information to transfer your medications. We can charge your debit or credit card for the applicable copay and shipping charges. **Shipping is free for Vantage Members**.

Please allow 48 hours to transfer and process the prescription(s) and an additional 2-3 days for the U.S. Postal Service to deliver.

WE CANNOT MAIL THE FOLLOWING: Controlled substances, Nitroglycerin SL tablets, or liquids (with the exception of insulin pens and vials, eye drops, and inhaled nebulization treatments).

Medication Name: ____________________ Prescription Number: ____________________

Pharmacy Name and Phone Number: ____

Medication Name: ____________________ Prescription Number: ____________________

Pharmacy Name and Phone Number: ____

Medication Name: ____________________ Prescription Number: ____________________

Pharmacy Name and Phone Number: ____

Medication Name: ____________________ Prescription Number: ____________________

Pharmacy Name and Phone Number: ____

Medication Name: ____________________ Prescription Number: ____________________

Pharmacy Name and Phone Number: ____

If you have more prescriptions, please use the alloted section on the back of this form or attach another page with the information on each.

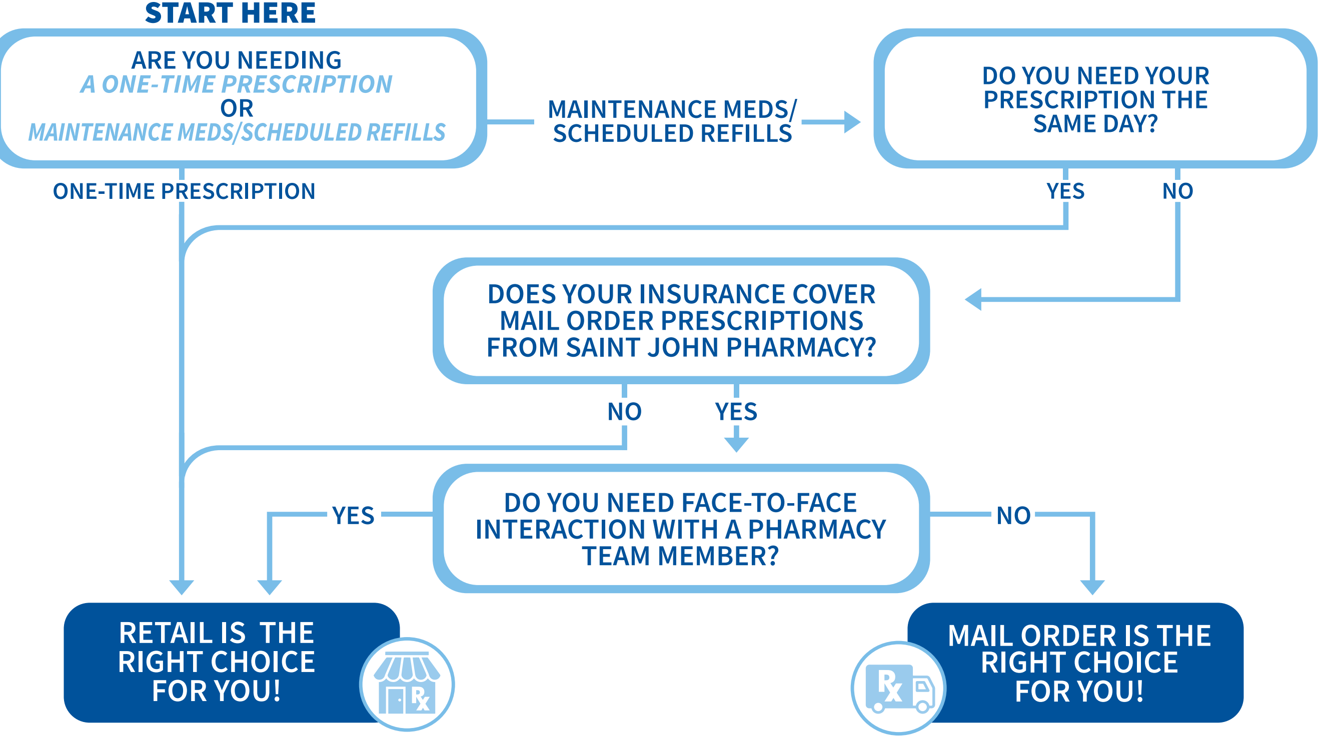
BILLING INFORMATION

Check credit card type or include a copy: Visa®   MasterCard®   Discover®   American Express®

Credit Card Number: ______________________________ Expiration Date: ______________

By signing below, I authorize Affinity Pharmacy to use the credit card information listed to provide payment on any outstanding balance.

Cardholder Signature: X ______________________________ Date: ______________



RETAIL

AFFINITY PHARMACY *at* St. John

110 St. John Street
Monroe, LA 71201

Phone: 318-807-4770
Toll-Free: 1-844-834-8839
Fax: 318-807-1831

APS@ahgphysician.com

AFFINITY PHARMACY *at* Oliver Road

920 Oliver Road *(Waiting Room E)*
Monroe, LA 71201

Phone: 318-807-6254
Toll-Free: 833-969-2896
Fax: 318-812-7346

APO@ahgphysician.com

MAIL ORDER

Phone: 318-807-1083
Toll-Free: 888-316-4354
Fax: 318-807-1079

SJP@ahgphysician.com

ADDITIONAL PRESCRIPTIONS

Use the following space to continue listing prescription medications from the front. If more space is needed, attach additional sheets.

Medication Name: ______________________ Prescription Number: ______________________
Pharmacy Name and Phone Number: ______________________

Medication Name: ______________________ Prescription Number: ______________________
Pharmacy Name and Phone Number: ______________________

Medication Name: ______________________ Prescription Number: ______________________
Pharmacy Name and Phone Number: ______________________

Medication Name: ______________________ Prescription Number: ______________________
Pharmacy Name and Phone Number: ______________________

Medication Name: ______________________ Prescription Number: ______________________
Pharmacy Name and Phone Number: ______________________

VHP815_020121_APPROVED