# New Prescription Form

**Depot Drug Mail Order Pharmacy**
**PO Box 165090**
**Salt Lake City, UT 84116-1020**
**Customer Services: 1-800-877-0618**

Please send this completed form along with your written prescriptions to the above address. Make certain to include your copayment check, money order, or debit/credit card information (please do not send cash). You will receive another form each time we send you a prescription.

Member Name _____ Phone (____) _____

Employer/Plan Name _____

ID Card #_____Medicare # _____

We will mail the prescription to the member's address on our file. Complete below if a different address is required.

Street Address_____

City, State, Zip _____

Copayments must be made at the time of order; otherwise the prescription(s) cannot be shipped. Copayments can be made with either a Visa or MasterCard credit/debit card.

☐ Use the credit/debit card already on file.

☐ Use the following Visa or MasterCard credit/debit card.

Credit Card Number Expiration Date

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Circle number of months to be filled at this time: 1 (one month) 2 (two months) 3 (three months)

**NOTE:** Depot Drug Mail Order Pharmacy will provide FDA-approved generic medications whenever possible, unless the physician indicates that a generic drug may not be substituted for a name brand medication. Copayments are much higher for name brand drugs.

Please allow 10 business days to receive your prescription.

Member Signature_____ Date _____

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