Physician Prescription Fax Form

Fax number: 801-595-4440

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

Physicians, please fax this completed form along with your written prescriptions directly from your office. We cannot accept faxed prescriptions from members.

Physician Name _____ Phone (____) _____

Fax (____)_____DEA# _____ NPI#_____

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

																XXX				

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 _____