

Please complete this form to submit your prescription(s), and mail or fax back to us to complete your order.

Full Name _____
Phone Number _____ Order Number (if available) _____

OPTION 1: Contact My Doctor

Primary Physician's Name _____
Clinic Name _____
Street Address _____
City _____ State/Province _____ Country _____ Zip/Postal Code _____
() () ()
Phone Number _____ Ext. _____ Fax Number _____

OPTION 2: Transfer From Another Pharmacy

Pharmacy Name _____
Street Address _____
City _____ State/Province _____ Country _____ Zip/Postal Code _____
() () ()
Phone Number _____ Ext. _____ Fax Number _____
Drug Names and/or Prescription Numbers _____

OPTION 3: Mail or Fax

Attach Your
Prescription
HERE

Please use a separate form for each written prescription

I will attach my prescription onto another page