



Mail Service Pharmacy Fax # 1-800-378-0323



FastStart® New Prescription Fax Form

This form can only be used for non-controlled drugs

If you would like to send a maintenance prescription to CVS Caremark Mail Service Pharmacy for your patient, please complete this form and fax it to the number above or ePrescribe (see step 4).

Step 1: Patient Information

Patient Name: _____ DOB: _____

Address: _____ Phone: (____) ____ - _____

City, ST, ZIP: _____

CVS Caremark Member ID#: _____ Prescription Benefit Provider _____

Allergy Information: _____

Step 2: Prescription Information

Prescription Date: _____

DRUG NAME	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
1. _____	_____	_____	90 days or _____	1 year or _____
2. _____	_____	_____	90 days or _____	1 year or _____
3. _____	_____	_____	90 days or _____	1 year or _____
4. _____	_____	_____	90 days or _____	1 year or _____

Prescriber signature: _____ May substitute Prescriber signature: _____ Dispense as written

Transmitted by: _____ (Full name if other than physician)

Step 3: Physician Information Required

Dr. Name: _____ Phone: (____) ____ - _____

Address: _____ Fax: (____) ____ - _____

City, ST, ZIP: _____

NPI #: _____ DEA #: _____

Step 4: Fax this form to 1-800-378-0323

Or e-Prescribe to CVS Caremark Mail Order Electronic, NCPDP ID 322038
9501 East Shea Blvd, Scottsdale, AZ 85260

This fax will only be accepted when sent from a prescriber's secure fax line.

If you are not the intended recipient of this FAX, you are hereby notified that any disclosure, copying or distributing is prohibited. If you have received this FAX in error or if you would like to talk to our staff, please notify us by phone toll-free at 1-800-378-5697. Plan participant privacy is important to us. Our employees are trained regarding the appropriate way to handle our plan participants' private health information.