

Prescription Request Form

Powered by: Truepill

Healthcare providers can use this form to send prescriptions directly to Mark Cuban Cost Plus Drug Company. IMPORTANT: Prescriptions can only be accepted if they include the email address associated with the patient's user account.

Save time by sending electronically eRX!

Prefer to call in the script?

Fax us this form

SEARC

This fax is void upless received directly from physician's office								
CH for "Mark Cuban Cost Plus Drug Company"	Call us at: 1-833-926-3384	Fax us at: 1-650-683-9775						

Patient information	This fax is void unless received directly from physician's office							
Email Address Required					For existi email a	ng patients, ddress on fil	this email must match the e with Cost Plus Drug Co.	
Last Name F			First Name				МІ	
Delivery Address				Apt., Ste. #				
City	State	Code	Phone Number (with area code)					
Date of Birth (mm/dd/yyyy) MM / DD	/ YYYY		(assigned at birth) emale O Male					
Prescription information			Ful	l formulary a	NC vailable at h	TE: We DO I ttps://costplu	NOT carry all medications. usdrugs.com/medications/	
Medication				Strength mg, ml, etc.		tity	Refills	
Directions Required			'		'		'	
Medication				Strength mg, ml, etc.		tity	Refills	
Directions Required								
Medication				Strength quant		tity	Refills	
Directions Required								
Medication				Strength Quanting, ml, etc.		tity	Refills	
Directions Required								
Generic substitution is permitted unless Prescriber information	prescriber include	es "DAW" or "c	dispense as writte	en." Pleas	se use a sepa	arate sheet f	or additional prescriptions	
Prescribing Physician Name Sup				upervising Physician's Name f applicable)				
Physician Phone Number Phy			Physician F (with area coo	nysician Fax Number ith area code)				
Physician Street Address				Unit #				
City	State	ZIP	NPI#			DEA#		
	·			Prescribing [(mm/dd/yyyy		IM / [DD / YYYY	
Physician Signature				////	, ,	•	•	

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