PRESCRIPTION REQUEST FORM

Name: (Last) (First) (M.I.)

Address:

Name of Medication:

Instructions for Use:

Area Code and Phone #:

Date of Birth:

Date Written:

Quantity to be Dispensed:

Day Supply:

Number of Refills:

Physician's Name: *Please Print*

Address:

Phone:

Fax:

Physician's Signature: *Stamps NOT ACCEPTED*

NPI::

DEA:

Mail Prescriptions to:
Elixir Pharmacy
7835 Freedom Avenue NW
North Canton, OH 44720

Toll Free: 866-909-5170 • Fax: 866-909-5171
elixirsolutions.com

Escribe: Use NABP 3677361 to send prescriptions electronically.

Call: Monday – Friday, 8:00am – 8:00pm (EST).

Fax: Prescriptions may be faxed directly from the physician's office to 866-909-5171.

elixir
PHARMACY