

**AFFILIATED PHARMACY SERVICES
Drug Prescription Order Form**

**PLEASE PRINT FORM AND MAIL TO
WESTGATE PHARMACY**

915 Union Street, Suite 7, Bangor, ME 04401

By submitting this form you are representing that the information provided is correct.

- Please print all information clearly with black or blue ink.
- Please complete Steps 1, 2, 3 and 4. Then complete Step 5 and/or 6 as needed. Incomplete information may delay processing.
- Please enclose payment method and original prescription(s) only. *Copies of pre-prescription(s) will not be accepted.*



STEP 1: INSURANCE CARDHOLDER INFORMATION

Cardholder ID# (See Insurance Card)	Cardholder's Full Name	TEMPORARY SHIPPING ADDRESS (FOR THIS ORDER ONLY)	
Address	State Zip Code (+4)	In Care of	
City		Name	
Home Phone ()	Work Phone ()	Temp City	Temp State
Cardholder's Employer	Contact E-mail	Temp Zip Code	Temp Phone ()

STEP 2: SHIPPING

If this section is left blank, Standard shipping will be used.
Refrigerated shipments will be expedited at no additional cost.

Check (✓) the box for the Shipping Method of your choice.
You are responsible for the cost of SPECIAL SHIPPING.

<u>Shipping Method</u>	<u># of Days</u>	<u>Cost</u>
<input type="checkbox"/> Standard Shipping	Standard Delivery	\$ 0.00
<input type="checkbox"/> USPS PRIORITY MAIL	2-3 Days	\$ 5.25
<input type="checkbox"/> USPS EXPRESS MAIL	Overnight	\$ 17.95

SPECIAL SHIPPING expedites carrier delivery time only. **Order Processing is not affected by SPECIAL SHIPPING.** These costs may be subject to change by carrier without prior notification and may vary depending on weight and zone

STEP 3: PAYMENT

Failure to include complete payment information may delay or prevent shipment of order.
Check (✓) the box for the Payment method of your choice.

- I authorize Affiliated Pharmacy Services to bill my credit card. I understand that my credit card will be billed the following amounts in effect at the time my order is filled: any applicable copayment(s), coinsurance and/or deductible(s), payments due for any medications not covered under my benefit plan, plus any special shipping costs. This credit card information will be used for all subsequent orders unless otherwise directed. Your receipt will be sent with your payment.

Check (✓) credit card type and enter corresponding credit card information below.

<input type="checkbox"/> Check here if this is a flex card <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa	Credit Card #
	Expiration Date
	Name on Credit Card

- I would like to pay full price for my medication(s). Do not bill my insurance.

Signature	Date
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Don't forget to complete the remaining steps on the reverse side.

STEP 4: ALLERGIES & HEALTH CONDITIONS

Please complete this section every time a medication is ordered.

Please be sure to (✓) any known allergies.

If no allergies are checked (✓), for any new customers this indicates no known allergies and for existing customers this indicates no change.

Patient's Full Name <small>Include nickname, Jr./Sr., etc.</small>	Male/ Female	Birth Date	None	Aspirin	Cephalosporins	Codeine	Erythromycin	Ibuprofen	Penicillin	Sulfa	Other Allergies	Major Health Conditions

STEP 5: REFILL PRESCRIPTIONS

For your convenience, you can order refills on line at www.affiliatedpharmacy.com, choose Westgate Pharmacy.
Do not include refills on this form that you plan to order on the internet. Refills from other pharmacies should not be included on this form.

Patient's Full Name	Birth Date	Affiliated Pharmacy Services RX Number	Medication Name and Strength
		RX#	
		RX#	
		RX#	
		RX#	

STEP 6: NEW PRESCRIPTIONS

THE MAINE STATE PHARMACY LAW REQUIRES PHARMACISTS TO SUBSTITUTE A LESS EXPENSIVE GENERICALLY EQUIVALENT MEDICATION FOR A BRAND NAME UNLESS YOUR PHYSICIAN INDICATES OTHERWISE. BY CHECKING (✓) "BRAND ONLY", YOU MAY INCUR A HIGHER COST.

Patient's Full Name	Birth Date	Check (✓) One		Medication Name & Strength	Check (✓) if Brand Only	Prescriber's/Physician's Full Name	Prescriber's/Physician's Phone Number
		Fill Now	Do Not Fill Now*				
							()
							()
							()
							()

*By checking this option, you are indicating you do not want the prescription filled at this time. Please contact Affiliated Pharmacy Services when this medication is needed

Attach the original prescription to the back of this form - your order cannot be filled without the original prescription.

Thank you for your order.

Should you need more information or have any questions, you can reach us at 1-800-639-8801
Monday through Friday 8-8, Saturday 9-5 and closed on Sundays
915 Union Street, Suite 7
Bangor, Maine 04401