MTF PRESCRIPTION PROGRAM
TRICARE Mail Order Pharmacy Registration and Prescription Form

86019

Today's Date : _____

Fax To:	877.250.8255	Overseas Fax: 602.586.3911
Mail To:	PO Box 52164 Phoenix, AZ 85072-9954	

** All Information REQUIRED - please indicate if N/A. Insufficient information may result in prescription delays.

Patient Information			
Last Name:	First Name:		MI:
Date of Birth	DEERS ID:		Phone:
Email:			
Mailing Address:			
City:	State:		Zip:
Allergies (Check In Category That Applies)			
No Known Drug ☐	Known Drug Allergies ☐	Specify:	

**The practitioner is responsible for ensuring the prescription conforms to all requirements of the law and regulations, both federal and state.
**DOD Policy requires dispensing of Generic Medication when available. If "YES" is marked below for Brand Medically Necessary, additional forms will be required for justification and authorization. Ensure patient is aware of any co-pays which may apply. To locate the applicable forms and determine copay information use the Formulary Search Tool (https://www.express-scripts.com/tricareformulary).

Drug Name and Formulation	Strength	Quantity	Directions	Refills
Write **"YES"** if Brand Medically Necessary:				
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Write **"YES"** if Brand Medically Necessary:				
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Write **"YES"** if Brand Medically Necessary:				

** All Credentials REQUIRED - please indicate if N/A. Insufficient credentials may result in prescription delays.

Prescriber Information		
MTF/Department:		
NPI#:	DEA# (Required for controls):	
Phone:	Fax:	Email:
Address:		
City:	State:	Zip:
Prescriber Name:	Signature:	
Supervising Physician:		

The provision of the information requested in this form is for your patient's benefit. Express Scripts does not compensate for completing this form.