Providing Affordable Medications

OVER 600 MEDICATION STRENGTHS AVAILABLE THROUGH OUR MAIL-ORDER PHARMACY

Follow these four simple steps...

STEP 1

See if you qualify.

You qualify for Rx Outreach as long as your annual household income is:

- ❑ **$35,310** or less for a single person
- ❑ **$47,790** or less for a family of two
- ❑ **$60,270** or less for a family of three
- ❑ **$72,750** or less for a family of four
- ❑ Add **$12,480** for each additional person

STEP 2

See if your medicine is on the attached Rx Outreach drug list.

Many drugs can be purchased for $20 for a 180-day supply. The list shows the administrative fees for all drugs offered. Administrative fees shown are for any dose, any strength. So even if you take more than one pill a day, our administrative fees are still the same!

STEP 3

Get a prescription from your doctor.

Prescriptions may be written with refills available for up to one year. Ask your doctor about a 180-day supply with one refill or a 90-day supply with three refills. Ask your doctor to e-prescribe your prescription. Rx Outreach is in the Surescripts network under NCPDP ID 2635855. Or, your physician may fax your prescription and application to 1-800-875-6591.

STEP 4

Mail the completed application, your original prescription(s) and your payment to:

Rx Outreach
P.O. Box 66536
St. Louis, MO 63166-6536

For more information, visit www.rxoutreach.org or call 1-888-RXO-1234 (796-1234), M-F, 7:00 a.m. to 5:30 p.m. Central time.

Rx Outreach is Not Insurance

Scan this code for more information about Rx Outreach

APPRX0785A - 10-1172

RX OUTREACH APPLICATION

TO ENROLL, PLEASE FILL OUT EACH FIELD

First name: ________________ Last name: ________________

Date of birth: ____ - ____ - ____ Social Security or Green Card #: (If you do not have a SSN / Green Card, write N/A) ________________

Address: ________________

City: ________________ State: ________ ZIP: ____________Circle one: Male / Female

Phone number: (______)______________E-mail:________________

Clinic or Physician Group (write N/A, if none):________________

Food / medications you are allergic to: ________________

Other Medication you are taking and medical conditions: ________________

____

____

Shipping address if different from above (Your shipping address must be a deliverable U.S. Post Office street address.):

Name: ____________ Address: ____________ City: ____________ State: ____ ZIP Code: ______

Income Information: Annual household income: $ ____________ Number of people in your house, including you: ________

What is the most important reason you are ordering medications from Rx Outreach? (Check one answer)

❑ Rx Outreach has the drug I need
❑ Rx Outreach was recommended to me
❑ Rx Outreach delivers to my home
❑ Price

You must sign the form before we can send your medicines. *I attest that the information provided in this application is complete and accurate. This authorization or a copy shall be valid for 12 months from the date of signature. I understand that Rx Outreach reserves the right to request income verification from me or refuse my application based on any misuse, abuse or illegal distribution of any products in this program. I will not seek reimbursement of any fee I pay to Rx Outreach from my health insurance, including Medicaid, Medicare or similar programs.*

Signature Required:________________ Date: ____ / ____ / ____

(If advocate/guardian signing on behalf of patient-please denote relationship and complete below)

Patient Advocate/Guardian Contact:________________ Phone: (______)________

Event Code
106

IF PLACING AN ORDER

How to Pay: Check or money order **payable to Rx Outreach,** or credit card. Please do not send cash.

FSA/Credit card/Debit card number: _ _ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _ Expiration date: _ _ / _ _

❑ Visa ❑ MasterCard ❑ Discover ❑ FSA are the only credit cards or debit cards accepted. Please check one.

I authorize Rx Outreach to charge this credit card for payment on my <u>first</u> order. Total Amount $ ________

Name on card: ________________ **Cardholder Signature:** ________________

(required if using a credit card)

TO ORDER CONTROLLED SUBSTANCES, YOU MUST ATTACH A COPY OF YOUR PHOTO ID CARD (for example, a driver's license or state ID card) <u>AND</u> A COPY OF YOUR SOCIAL SECURITY CARD OR GREEN CARD (or a copy of your paystub-must show SS# or latest income tax form). Controlled substances and non-controlled medications will ship separately. We cannot ship controlled substances to a P.O. box or a doctor's office. (Controlled Substances are: Alprazolam, Chlordiazepoxide, Clonazepam, Diazepam, Diphenoxylate/Atropine, Donnatal, Eszopiclone, Lorazepam, Modafinil, Oxandrolone, Temazepam, Tramadol, Zaleplon, Zolpidem and Zolpidem ER).

You can mail in the application and prescription or fax to 1-800-875-6591
(Faxed prescriptions must come directly from the doctor's office)