AcesoRx

Thank you for using *AcesoRx*. We appreciate your business.

Prescription Order Form

It's easy! Choose your preferred method of ordering:

Call **888.697.9646** to complete a new registration or refill a prescription you have previously filled with AcesoRx . Alternatively, your physician/licensed health care provider can:

1. E-scribe (electronically submit) – to Specialty Medical Drugstore (KY or OH location)
2. Phone in prescription – to 888.697.9646 (9:00 am – 7:00 pm, M-F; 9.00 am – 1.00 pm Saturday (Eastern Time); or
3. Fax prescription – to 888.697.0646

Complete the applicable sections of this form and mail it along with payment and your original prescription to:
Rx 'n Go c/o Transition Pharmacy (NPI # 1336325265), 2546 Metropolitan Dr, Trevose, PA 19053

Member Information

Name: _____ Date of Birth: ____/____/_____ Gender M/F: _____

Address*: _____ Apt.: _____ Phone #: (_____) _____ — _____

City, State, Zip: _____ E mail: _____

How did you hear about us? _____ * Prescriptions will be sent to address provided.

Medical History Information: *Skip this section if medical history on file has not changed.*

Complete this section when placing your first order or if your medical history has changed:

Physician's Name: _____ Physician's Ph: ( ) _____ — _____

Please list any health conditions, drug allergies, or other medications you are taking in the space below or on a separate page.

_____

_____

_____

Talk to your physician about all of your current medication in order to avoid potential harmful interactions. If you have questions about drug interactions or side effects, you may speak with a pharmacist at the mail order pharmacy by calling 888.697.9646

Refill Prescription Information: *Complete this section only if you have a valid prescription with authorized refills on file at Rx 'n Go.*

Please apply the bar code label from your last order or list the prescription number(s) and the name of the medication you are ordering in the spaces below.

RX#: _____ RX name: _____ **Auto Refill** ☐

RX#: _____ RX name: _____ **Auto Refill** ☐

RX#: _____ RX name: _____ **Auto Refill** ☐

"Controlled substances cannot be auto refilled

Payment Information:

Amount $ _____ ☐Check ☐Money Order Credit Card: ☐AMEX ® ☐ Discover® ☐MasterCard® ☐Visa®

Please complete the following information if you are paying by credit card:

Cardholder's Name: _____ Card Number: _____ Exp. Date _____

I authorize ECB Rx, LLC c/o Transition Pharmacy Services, LLC to charge the credit card indicated above all charges pertaining to the new and/or refill prescription requests included with this form. I attest that I am a legal, authorized user of the designated card.

Signature _____

By registering, I agree to the Privacy Policy of AcesoRx . For a complete copy of the policy, please visit www.acesorxmail .com or call 888,697.9646. AcesoRx is not a pharmacy. Pharmacy services are provided by Transition Pharmacy Services, LLC