

Rx Outreach[®]

PREFERRED CLINIC PROGRAM



WHAT IS THE PREFERRED CLINIC PROGRAM?

The Preferred Clinic Program has a streamlined, easy to administer application process. A customized, consolidated application/prescription form, detailed shipping statements, and bi-monthly billing minimize administrative time. Our unique form combines the patient application and the prescription into one easy-to-complete process. Less paperwork means the clinic staff can focus more time on patients.

HOW DOES THE PROGRAM WORK?

The clinic/health provider will contract with Rx Outreach to utilize this method of service for their facility. A clinic/health provider will be able to submit multiple patient forms via fax or by mail (clinic/provider will pre-qualify patients based on the 300% FPL). All prescriptions will be shipped directly to your facility for distribution to the patient, with the exception of controlled substances—they will be shipped to the patient address provided. Payment is not required when you place your orders; an itemized invoice is sent at the close of each billing cycle (bi-monthly) indicating all orders processed during that period. Payment is required upon receipt of the invoice.

(See Reverse for Detailed Program Information)



PREMIER CHRONIC DRUG FORMULARY



MEDICATIONS WILL BE DELIVERED DIRECTLY TO YOUR FACILITY



NO UPFRONT PAYMENT

WE ARE AVAILABLE TO ASSIST YOU.

If you have questions about your orders, please call us toll-free at 1.800.769.3880. Customer service representatives and pharmacists are available Monday through Friday, 7:00am–5:30pm Central time, to answer questions and provide assistance.

TO LEARN MORE ABOUT THE PROGRAM:

Please contact Marsha England, Director of Client Services, at 1-888-408-1079 ext. 6140 or email at marsha.England@rxoutreach.org.

1.800.769.3880
www.rxoutreach.org

CUSTOMIZED PRESCRIPTION FORMS

Prescription forms (Figure 1) are specially coded forms that enable you to order medications from Rx Outreach. A supply of these forms will be provided by Rx Outreach upon acceptance of the program.

FIGURE 1

Rx Outreach
A SAFE, AFFORDABLE, AND EASY WAY TO GET MEDICINES YOU NEED.

Mail Order to:
Rx Outreach
PO Box 66536
St. Louis, MO 63166-6536

STEP 1 – PATIENT SECTION

Patient Name _____ Date / /
mm dd yyyy

Patient Shipping Address: _____ City _____ State _____ Zip _____

Date of Birth / / Patient ID/SSN _____ Clinic Participant ID Number _____
mm dd yyyy

Allergies _____

Other medications you are taking and medication conditions _____

STEP 2 – PHYSICIAN SECTION (Please refer to product list on the back of this form when filling out drug name)
PLEASE DO NOT USE FORM BELOW FOR CONTROLLED SUBSTANCES – ATTACH SEPARATE PRESCRIPTION.

Rx 1 – Drug Name _____ Strength _____
Directions _____ Quantity 90 Days **180 Days** Refills (Check One) 1 2 3

Rx 2 – Drug Name _____ Strength _____
Directions _____ Quantity 90 Days **180 Days** Refills (Check One) 1 2 3

Rx 3 – Drug Name _____ Strength _____
Directions _____ Quantity 90 Days **180 Days** Refills (Check One) 1 2 3

PHYSICIAN MUST SIGN BELOW. PLEASE ATTACH ANY ADDITIONAL PRESCRIPTIONS TO THIS FORM.

SUBSTITUTION PERMITTED (Physician Signature) / / Dispense as Written
mm dd yyyy

Physician Name _____ DEA Number _____ Phone _____
Address _____ City _____ State _____ Zip _____

Type PRFCS 0610

CLINIC NAME
CLINIC ADDRESS
CLINIC CITY STATE ZIP

CLINIC ID #

Rx Outreach only offers the medications listed on the back of this form. Please make sure a medication is on the list before you complete the form.

Fax Order to:
1-888-430-9818

Helping Families in Need



REFILL INFORMATION

A monthly refill report (Figure 2) will be sent to your clinic when it is time to order refills. This report will consist of three sections: **Refills Remaining**, **Zero Refills Remaining (new script required)**, and **Expired Script (new script required)**. Simply check the box next to the prescriptions that you need refilled and fax back to Rx Outreach.

FIGURE 2

Rx Outreach
A SAFE, AFFORDABLE, AND EASY WAY TO GET MEDICINES YOU NEED.

Monthly Refill Report
Report Date Range: 3 month supply: 20-May-10 through 20-Jun-10
Report Date Range: 6 month supply: 20-Feb-10 through 20-Mar-10
Report Expiration Date: 6-Aug-10

Organization: 170-OR150081-01 ABC Clinic, 123 Main St, Anywhere, USA 60000

REFILLS REMAINING										
Refill	Ship Date	Patient	Script#	NDC	Days Supply	Quantity	Fills Remaining	Discard Date	X-Fill	Status
Refill	3/24/2010	150003	FIRST LAST	10557024	23165000310	DRUG DESCRIPTION	180	360	1	3/22/2011
Refill	3/3/2010	059058	FIRST LAST	10584400	0111048203	DRUG DESCRIPTION	180	360	1	2/29/2011
Refill	6/9/2010	1875851	FIRST LAST	10518247	03101510	DRUG DESCRIPTION	90	180	3	6/2/2011
Refill	6/9/2010	1745674	FIRST LAST	10518246	03101510	DRUG DESCRIPTION	90	180	3	6/2/2011

CHECK HERE TO REFILL ALL VALID SCRIPTS

SIGNATURE: _____

PRESCRIPTIONS WITH A STATUS OF NO REFILLS OR EXPIRED REQUIRE A NEW SCRIPT. ALL NEW PRESCRIPTIONS MUST BE SUBMITTED USING THE CURRENT PRESCRIPTION FORM AND METHOD.

ZERO REFILLS REMAINING										
Refill	Ship Date	Patient	Script#	NDC	Days Supply	Quantity	Fills Remaining	Discard Date	X-Fill	Status
Zero Refill	3/15/2010	663861	FIRST LAST	10396210	03165000310	DRUG DESCRIPTION	180	360	0	1/12/2011
Zero Refill	3/15/2010	057095	FIRST LAST	10396206	03165000310	DRUG DESCRIPTION	180	360	0	1/12/2011
Zero Refill	3/15/2010	652487	FIRST LAST	10444520	0111048203	DRUG DESCRIPTION	180	360	0	1/14/2011
Zero Refill	3/15/2010	114760	FIRST LAST	10396217	03165000310	DRUG DESCRIPTION	180	360	0	1/12/2011
Zero Refill	3/15/2010	1462619	FIRST LAST	10444517	03165000310	DRUG DESCRIPTION	180	360	0	1/12/2011
Zero Refill	3/15/2010	6837209	FIRST LAST	10396211	03165000310	DRUG DESCRIPTION	180	360	0	1/12/2011
Zero Refill	3/15/2010	019218	FIRST LAST	10444510	03165000310	DRUG DESCRIPTION	180	360	0	1/12/2011

EXPIRED SCRIPT - NEW SCRIPT REQUIRED
There are currently no prescriptions that meet this criteria.

COMPLETING THE PRESCRIPTION FORM

When completing the customized form, remember to include the following required information:

- Date, Patient Name, Date of Birth
- Clinic Participant ID
- Physician DEA or State License Number
- Original Physician Signature

The DEA number only needs to be provided the first time each of your physicians completes a prescription. That information will be held in our database for all future submissions. Please refer to the drug list provided on the reverse side of the Prescription Form to complete the drug name. Include any allergies that may apply, be sure to include the applicable medication strength, and check the quantity box to make sure you have indicated any requested refills.

PAYMENT AND TRANSACTION DATA

Rx Outreach will invoice the participating clinic on a bi-monthly basis for all transactions occurring in the previous billing cycle. Along with the invoice, the clinic will receive detailed transaction data describing each shipment.

SUBMITTING INFORMATION

Mail or fax completed forms to:

Rx Outreach
P.O. Box 66536
St. Louis, MO 63166-6536
Fax: 888-430-9818