Home Delivery 90-Day Order Form

To be completed by a prescriber and faxed to 888-282-1349

1 Patient information. Please use black or blue ink.

Last Name	First Name	MI	Gender ☐ M ☐ F
Delivery Address		Apt. #	
City	State	ZIP	
Date of birth / /	Email	Phone	

2 Health history

Medication Allergies:

- ☐ Amoxil/Ampicillin
- ☐ Aspirin
- ☐ Cephalosporins
- ☐ Codeine
- ☐ Erythromycin
- ☐ NSAIDs
- ☐ Penicillin
- ☐ Quinolones
- ☐ None Known
- ☐ Sulfa
- ☐ Tetracyclines
- ☐ Others: ____________

Health Conditions:

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ None Known
- ☐ Osteoporosis
- ☐ Thyroid Disease
- ☐ Others: ____________

List all prescription, over-the-counter and herbal medications taken regularly: (use additional sheet if necessary)

3 Prescription information

Drug Name & Strength	Qty	Directions	DAW	Refills

4 Prescriber information

Prescriber's Name	DEA#	NPI#
Phone	Fax	
Address		
Prescriber Signature		Date

Magellan Rx - 6870 Shadowridge Drive, Suite 111, Orlando, FL 32812. Phone 800-424-8274 - Fax 888-282-1349 - NPI 1558738864 - DEA BI8515047

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*** THIS FORM IS NOT VALID IN THE STATE OF ARIZONA ***

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