

Uniform New Jersey Prescription Blanks Order Form

CUSTOMER INFORMATION		FOR INTERNAL USE ONLY	
COMPANY NAME		COMPANY NAME	
STREET ADDRESS (REQUIRED FOR UPS SHIPMENT)		STREET ADDRESS (REQUIRED FOR UPS SHIPMENT)	
CITY, STATE AND ZIP		CITY, STATE AND ZIP	
PHONE NUMBER (INCLUDE AREA CODE) () ()	FAX NUMBER (INCLUDE AREA CODE) () ()	PHONE NUMBER (INCLUDE AREA CODE) () ()	FAX NUMBER (INCLUDE AREA CODE) () ()
SIGNATURE OF PURCHASER	EMAIL ADDRESS	SIGNATURE OF PURCHASER	EMAIL ADDRESS

Ordering Instructions:

1. Per state requirements, all orders and reorders for Uniform New Jersey Prescription Blanks must be submitted in writing via mail or fax.
2. Use one Order Form per prescription order. Multiple prescriber names and one address may be printed on the front of each prescription. Additional addresses may be printed on the back for an additional cost.
3. The address used for shipping must match with the listing of authorized prescribers and health care facilities on file with the licensing board.
4. License numbers must be provided for each prescriber or facility.
5. The signature of each authorized prescriber or health care facility representative must be provided with each order.

ORDERING INFORMATION: Please Check One

Healthcare

State of New Jersey
PRESCRIPTION BLANK

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

PATIENT _____ D.O.B. _____
ADDRESS _____ DATE _____

Rx

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____
DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____
REFILL _____ TIMES

Use separate form for each controlled substance prescription
THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW

State of New Jersey
PRESCRIPTION BLANK

DELEGATED PHYSICIAN SUPERVISOR
LICENSE # _____

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

PATIENT _____ D.O.B. _____
ADDRESS _____ DATE _____

Rx

NOT VALID FOR CONTROLLED SUBSTANCES

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____
DO NOT REFILL _____ SIGNATURE OF PHYSICIAN ASSISTANT _____
REFILL _____ TIMES

THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW

State of New Jersey
PRESCRIPTION BLANK

DEAR: _____ CERTIFICATION# _____
BATCH# _____ SERIAL# _____
COLLABORATING PHYSICIAN

NAME _____ LICENSE # _____
ADDRESS _____ PHONE # _____

PATIENT _____ (Enter Address & Phone # only if different from above)
ADDRESS _____ DATE _____

Rx

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____
DO NOT REFILL _____ SIGNATURE OF ADVANCED PRACTICE NURSE & TITLE _____
REFILL _____ TIMES

THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW

State of New Jersey
PRESCRIPTION BLANK

COLLABORATIVE PHYSICIAN

NAME _____ TELEPHONE # _____
ADDRESS _____
CITY _____ LICENSE # _____

PATIENT _____ D.O.B. _____
ADDRESS _____ DATE _____

Rx

NOT VALID FOR CONTROLLED SUBSTANCES

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____
DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____
REFILL _____ TIMES

THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW

- ### MD, DO, DDS, DMD, DPM, DVM, VMD, MVSc
- 445821 1-Part
 - 445821B 1-Part, Alternate Address
 - 445821-2 2-Part
 - 445821B-2 2-Part, Alternate Address

- ### Physician Assistant
- 7823 1-Part
 - 7823B 1-Part, Alternate Address
 - 7820 2-Part
 - 7820B 2-Part, Alternate Address

- ### Advanced Practice Nurse
- 445801 1-Part
 - 445801B 1-Part, Alternate Address
 - 445801-2 2-Part
 - 445801B-2 2-Part, Alternate Address

- ### Certified Nurse Midwife
- 445811 1-Part
 - 445811B 1-Part, Alternate Address
 - 445811-2 2-Part
 - 445811B-2 2-Part, Alternate Address

Optometrist

State of New Jersey
PRESCRIPTION BLANK

PRINT ABOVE NAME AND TITLE OF PRESCRIBER AND IF APPLICABLE, COLLABORATING PHYSICIAN
CHECK BY: APRN CHM PA PRESCRIBER COLLABORATING PHYSICIAN

PATIENT _____ D.O.B. _____
ADDRESS _____ DATE _____

Rx

NOT VALID FOR CONTROLLED SUBSTANCES IF ISSUED BY: OPTOMETRIST, MIDWIFE OR PHYSICIAN ASSISTANT

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____
DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____
REFILL _____ TIMES

Use separate form for each controlled substance prescription
THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW

State of New Jersey
PRESCRIPTION BLANK

VALID ONLY FOR PRESCRIPTION EYE WEAR

PATIENT _____ D.O.B. _____
ADDRESS _____ DATE _____

Rx	SPHERE	CYLINDER	AXIS	PRISM
OD				
OS				
ADD	P.D. _____ / _____			
ADD	REMARKS:			

DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____
REFILL _____ TIMES

THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW

State of New Jersey
PRESCRIPTION BLANK

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

PATIENT _____ D.O.B. _____
ADDRESS _____ DATE _____

Rx

NOT VALID FOR CONTROLLED SUBSTANCES, VALID FOR TYPICAL PHARMACEUTICAL AGENTS OF TPA CERTIFIED AND PRESCRIPTION EYEWEAR ONLY

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____
DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____
REFILL _____ TIMES

THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW

State of New Jersey
PRESCRIPTION BLANK

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

PATIENT _____ D.O.B. _____
ADDRESS _____ DATE _____

Rx

NOT VALID FOR CONTROLLED SUBSTANCES, VALID FOR TYPICAL PHARMACEUTICAL AGENTS IF TPA CERTIFIED AND PRESCRIPTION EYEWEAR ONLY

Rx	SPHERE	CYLINDER	AXIS	PRISM
OD				
OS				
ADD	P.D. _____ / _____			
ADD	REMARKS:			

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____
DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____
REFILL _____ TIMES

THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW

- ### Health Care Facility
- 445831 1-Part
 - 445831B 1-Part, Alternate Address
 - 445831-2 2-Part
 - 445831B-2 2-Part, Alternate Address

- ### For Exclusive Use When Prescribing Eyewear
- 445861 1-Part
 - 445861B 1-Part, Alternate Address
 - 445861-2 2-Part
 - 445861B-2 2-Part, Alternate Address

- ### Optometrists (without eyewear box)
- 445841 1-Part
 - 445841B 1-Part, Alternate Address
 - 445841-2 2-Part
 - 445841B-2 2-Part, Alternate Address
 - Check for contact lens warning

- ### Optometrists (with eyewear box)
- 445851 1-Part
 - 445851B 1-Part, Alternate Address
 - 445851-2 2-Part
 - 445851B-2 2-Part, Alternate Address
 - Check for contact lens warning

PRICING: Please Check One (Prices subject to change without notice.)

1-Part Pads (100 blanks per pad)
5 pads (500 blanks) | 10 pads (1000 blanks) | 20 pads (2000 blanks) | 30 pads (3000 blanks) | 40 pads (4000 blanks) | 50 pads (5000 blanks) | 100 pads (10,000 blanks)

1-Part Pads with Alternate Address (100 blanks per pad)
5 pads (500 blanks) | 10 pads (1000 blanks) | 20 pads (2000 blanks) | 30 pads (3000 blanks) | 40 pads (4000 blanks) | 50 pads (5000 blanks) | 100 pads (10,000 blanks)

2-Part Carbonless Pads (50 sets per pad)
10 pads (500 sets) | 20 pads (1000 sets) | 40 pads (2000 sets) | 60 pads (3000 sets) | 80 pads (4000 sets) | 100 pads (5000 sets) | 200 pads (10,000 sets)

2-Part Carbonless Pads with Alternate Address (50 sets per pad)
10 pads (500 sets) | 20 pads (1000 sets) | 40 pads (2000 sets) | 60 pads (3000 sets) | 80 pads (4000 sets) | 100 pads (5000 sets) | 200 pads (10,000 sets)

Check here for Consecutive Numbering (optional).

Starting #: _____

Subtotal	
Add appropriate Sales Tax* *We are required to charge sales tax based on your state regulations.	
TOTAL	

Information to be printed on Prescription Blank:

- Practice or Facility Name (if to be printed): _____
- Prescriber Name: _____ Degree: _____
- Practice or Specialty (only if to be printed on pads below prescriber name(s)): _____ License # _____

Address to be printed on front: _____ **STREET ADDRESS**

_____ **CITY** National Provider Identifier # (NPI #): _____

Telephone # to be printed: _____ Fax # (if to be printed): _____

- Specify if Applicable: DEA# _____ TPA Cert # _____
(If DEA # is not provided, a blank line will be printed to be filled in by prescriber where applicable.) (For Opto, must be printed.)

Facility Provider # _____ Certification # _____

***** **Needed each time order is placed** *****
 *
 *
 * **Prescriber** *
 * **Signature:** _____ *
 *

IMPORTANT: If more than one prescriber is listed on the same blank, one of the prescribers is to be responsible for the shipment. That person must sign below:

PLEASE NOTE: By signing, you are the responsible party for this shipment of prescription blanks. Please make certain that the ship to address given below is the same as it appears with your medical licensing board.

Optional: Additional doctors to be printed on the same prescription blank (or one collaborating physician if ordering pads for Nurse Practitioner/Certified Nurse Midwife/Physician Assistant):

- | | |
|--|--|
| 1. Prescriber Name: _____
License #: _____ Degree: _____
DEA#: _____ NPI #: _____
*Prescriber Signature: _____ | 2. Prescriber Name: _____
License #: _____ Degree: _____
DEA#: _____ NPI #: _____
*Prescriber Signature: _____ |
| 3. Prescriber Name: _____
License #: _____ Degree: _____
DEA#: _____ NPI #: _____
*Prescriber Signature: _____ | 4. Prescriber Name: _____
License #: _____ Degree: _____
DEA#: _____ NPI #: _____
*Prescriber Signature: _____ |

Optional: Additional addresses to be printed on the back of the prescription blanks (must include phone number):
If additional addresses are required, attach separate sheet (up to 4 addresses).

Street: _____ Street: _____
 City, State, Zip: _____ City, State, Zip: _____
 Phone: () _____ Phone: () _____

Bill To: _____ **Ship To: Official address on file with the State Board**

Practice Name _____	Practice Name _____
Address _____ Room/Suite/Bldg. _____	Address _____ Room/Suite/Bldg. _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Attention _____ Phone _____	Attention _____ Phone _____

For Reorders – Attach a sample of original Prescription Blank for faster processing.