Rx Outreach®
The Nonprofit Pharmacy

Providing Affordable Medications

OVER 800 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:

- ❑ **$36,420** or less for a single person
- ❑ **$49,380** or less for a family of two
- ❑ **$62,340** or less for a family of three
- ❑ **$75,300** or less for a family of four
- ❑ Add **$12,960** 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 medication costs for all drugs offered. If you don't see it on the printed list, you may find it on line. The price listed is the price you pay! We do not charge additional or hidden fees.

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

BBB ACCREDITED CHARITY bbb.org

Rx Outreach® The Nonprofit Pharmacy

RX OUTREACH APPLICATION

TO ENROLL, PLEASE FILL OUT EACH FIELD

First name: _____ Last name: _____

Date of birth: _____ - _____ - _____

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: _____

How did you learn about Rx Outreach?

❑ Doctor ❑ Social Service Organization ❑ Other

❑ Clinic/Healthcare Facility ❑ Self/Family

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
788

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 first 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). 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, Androxy, Chlordiazepoxide, Clonazepam, Dexmethylphenidate, Dextroamphetamine-Amphetamine, Dextroamphetamine-Amphetamine ER, Dextroamphetamine sulfate ER, Diazepam, Diphenoxylate/ Atropine, Donnatal, Eszopiclone, Lorazepam, Modafinil, Methylphenidate, Methylphenidate CD, Methylphenidate LA, Oxandrolone, Temazepam, Testosterone, 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)