Providing Access to Affordable Medications

OVER 1,000 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:
- $37,470 or less for a single person
- $63,990 or less for a family of three
- Add $13,260 for each additional person
- $50,730 or less for a family of two
- $77,250 or less for a family of four

**STEP 2**
See if your medicine is on the attached Rx Outreach drug list.
If you do not see your medication on the attached list, please visit our website. The price listed for each medication is the price you pay. We do not charge any additional 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

*supported through a partnership
First name: __________________________ M.I.: __________ Last name: __________________________

Date of birth: ___ - ___ - ______

Address: ____________________________________________________________

City: __________________________ State: _______ ZIP: __________________________

Phone number: (______)__________________________________________

Patient Advocate/Guardian Contact: (if applicable)________________________ Phone: (______)__________________________________________

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.) to:

Name: ____________________________________________________________

Address: ____________________________________________________________ City: __________________________ State: _______ ZIP Code: __________________________

Annual household income: $ __________________________ Number of people in your house, including you: _______

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)

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, and they must be signed for upon delivery. Controlled substances are identified by “CS” on the medication list.

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).