

Step 1: Complete your Membership Application

First Name: _____ MI: _____ Last Name: _____

Date of Birth: ____/____/____ Email: _____ Opt in for emails

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

 Male Female Cell Home Opt in for text messages**MEDICAL CONDITION(S)** Please check all that apply Heart Disease Alzheimer's Arthritis Diabetes Cancer Other

Medication allergies (if applicable): _____

Medication(s) you are currently taking: _____

ELIGIBILITY**Income Information:**

Annual household income: \$ _____ Number of people in your household, including you: _____

You must sign this form before we can send your medication(s). 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 the 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 product 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 complete section below)Event Code
788

Patient's advocate / guardian contact (if applicable) _____

Relationship: _____ Phone: (____) _____

Scan the code using your smartphone
camera app or visit the websiterxoutreach.org/find-your-medication**TO ORDER CONTROLLED SUBSTANCES, YOU MUST ATTACH A COPY
OF YOUR GOVERNMENT ISSUED PHOTO ID CARD.****To protect your safety, controlled substances and expedited shipping 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)

No prescription is needed for these medications. Please indicate all medications you would like to order on the prescription submission form. OTC orders will be applied to approved payment method. Prices subject to change.

First Name: _____ MI: _____ Last Name: _____

Date of Birth: ____/____/____ Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Over the Counter Medications and Products				
Product			Price	Quantity to Order
Allergies				
Budesonide Nasal Spray	32mcg	Rhinocort®	Allergy	\$22 per bottle (min. 2 bottles)
Cetirizine Tablet	10mg	Zyrtec®		\$10 per bottle of 100 tablets (min. 2 bottles)
Fexofenadine Tablet	60mg	Allegra®		\$40 per bottle of 100 tablets
Fexofenadine Tablet	180mg	Allegra®		\$40 per bottle of 100 tablets
Loratadine Tablet	10mg	Claritin®		\$10 per bottle of 100 tablets (min. 2 bottles)
Diabetic Supplies				
Glucose Monitor (ProdigyAutocode®)				One Free Monitor Per Year* (with order of test strips)
Glucose Control Solution Low (Prodigy®)	4mL bottle			\$5 per bottle (Vial)
Glucose No Coding Test Strips (Prodigy®)	Box of 50 strips			\$15 per box
Glucose TwistTop Lancets 28G (Prodigy®)	Box of 100 lancets			\$5 per box (min. 2 boxes)
Eye Drops				
Ketotifen Ophthalmic Solution 0.025%	5mL bottle	Zaditor®		\$9 per bottle
Pain Relievers				
Aspirin EC Coated Tablet	325mg			\$7 per bottle of 100 tablets
Aspirin EC Coated Tablet	81mg			\$9 per bottle of 120 tablets
Capsaicin Cream 0.025%	60gm tube			\$12 per tube
Supplements				
Docusate Sodium	250mg			\$9 per bottle of 100 tablets
Ferrous Sulfate EC Tablet	325mg			\$6 per bottle of 100 tablets (min. 2 bottles)
Magnesium Oxide Tablet	400mg			\$8 per bottle of 120 tablets
Melatonin Tablet	5mg			\$7 per bottle of 60 tablets (min. 2 bottles)
Niacin SA Capsule	250mg			\$9 per bottle of 100 capsules
Vitamin B-6 Tablet	50mg			\$11 per bottle of 100 tablets
Vitamin B-6 Tablet	100mg			\$7 per bottle of 100 tablets
Vitamin D3 Capsule	50,000IU			\$15 per bottle of 12 capsules
Vitamin D3 Tablet	400IU			\$11 per bottle of 100 tablets

*restrictions apply

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www.rxoutreach.org

Join online through our website, or call 1-888-796-1234, or fill out this application and mail.

Rx Outreach

3171 Riverport Tech Center Dr., Maryland Heights, MO 63043
 Phone: 1-888-796-1234; Fax: 1-800-875-6591
 Hours: Mon-Thurs: 7am-7pm CT
 Fri: 7am-5:30pm CT; Sat: 9am-2pm CT



Step 2: Submit Your Prescription

Full Name: _____

D.O.B. _____ Phone (____) _____

Option A: Your Doctor will send prescription
Ask your doctor to send your prescription to Rx Outreach:
① By E-Script
② By Phone: 1-888-796-1234
③ By Fax: 1-800-875-6591

Option B: I will mail in the Rx Outreach Membership Application and my prescription
Rx Outreach, 3171 Riverport Tech Center Dr.
Maryland Heights, MO 63043

Option C: Rx Outreach requests transfer from another pharmacy.
Please list the medications that you would like transferred from another pharmacy.

Pharmacy Name _____ (____) _____ (____) _____
Phone Number Fax Number
Doctor's Name _____

Medication Name	Strength	Quantity Requested

Option D: Rx Outreach requests prescription from your doctor.
Please list the medications that you would like requested from your doctor.

Doctor's Name _____ (____) _____ (____) _____
Phone Number Fax Number

Medication Name	Strength	Quantity Requested

Step 3: Choose a Payment Method

Pay by Credit, Debit Card, or FSA.

OR Pay by check or Money Order.

Cardholder's Name _____

Credit Card Number _____

Expiration Date (MM/YY) / / CVV _____

I authorize Rx Outreach to charge this credit card for payment on my **first** order up to \$ _____

I will make a payment by check or money order, and mail it to:

Rx Outreach
3171 Riverport Tech Center Dr.
Maryland Heights, MO 63043