Follow these four simple steps...

**STEP 1**
See if you qualify.
You qualify for Rx Outreach as long as your annual household income is:

- $35,640 or less for a single person
- $60,480 or less for a family of three
- $48,060 or less for a family of two
- $72,900 or less for a family of four

- Add $12,420 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 administrative fees for all drugs offered. Administrative fees shown are for any dose, any strength. So even if you take more than one pill a day, our administrative fees are still the same!

**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
RX OUTREACH APPLICATION

TO ENROLL, PLEASE FILL OUT EACH FIELD

First name: __________________________ Last name: __________________________

Date of birth: ______ - ______ - ______ Social Security or Green Card #: (If you do not have a SSN / Green Card, write N/A) __________________________

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: (______) __________________________

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, Chlordiazepoxide, Clonazepam, Dexamethasone, Dextroamphetamine-Amphetamine, Dextroamphetamine-Amphetamine ER, Dextroamphetamine sulfate ER, Diazepam, Diphenoxylate/Atropine, Donnatal, Eszopiclone, Lorazepam, Modafinil, Methylenidate, Methylenidate CD, Methylenidate LA, Oxandrolone, Temazepam, 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).

Event Code 788