

NEW JERSEY PRESCRIPTION FORMS

Below are the standard layouts we will use on all New Jersey Prescription Forms.
Please see the order sheet for specific instructions.

Size 4" x 5½" - Face-Reflex Blue/Back-Green - Imprint Information Black

State of New Jersey
PRESCRIPTION BLANK

FACILITY NAME
DOCTOR
SPECIALTY
STREET
CITY STATE ZIP

DEA # _____ PHONE _____ LIC. # 0000000
BATCH # PRT00000000000 NPI # _____ SERIAL # 000001

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

#1 MD, DO, DDS, DMD, DPM, DVM

State of New Jersey
PRESCRIPTION BLANK

NAME OF INSTITUTION OR FACILITY

STREET ADDRESS
CITY, STATE, ZIP FACILITY PROVIDER #:
TELEPHONE: _____ CITY, STATE, ZIP SERIAL #: 000001

BATCH # PRT00000000000 SERIAL #: 000001

PRINT CLEARLY: NAME & TITLE OF PRESCRIBER & IF APPLICABLE, SUPERVISING / COLLABORATING PHYSICIAN

CHECK APR DDM PA PRT SPD
LICENSURE / CERT. / RX AUTHORIZATION # _____ DEA # 00000000000
NPI # _____ 00000000000

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

Rx

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

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#2 Health Care Facility

State of New Jersey
PRESCRIPTION BLANK

NAME OF PRACTICE
NAME AND ACADEMIC DEGREE
IDENTIFICATION OF PROF. PRACTICE OR SPECIALTY
STREET ADDRESS
CITY, STATE, ZIP CODE
LIC. # 0000000 CITY, STATE, ZIP CODE DEA # _____
CERT. # _____ TELEPHONE NPI # _____
BATCH # PRT00000000000 SERIAL # 000001

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 SCHEDULE II CONTROLLED DANGEROUS SUBSTANCES.

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

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#3 Optometrist TPA Certified

State of New Jersey
PRESCRIPTION BLANK

NAME AND TITLE
STREET ADDRESS
CITY, STATE ZIP
TELEPHONE

DEA # _____ CERTIFICATION # _____
BATCH # PRT00000000000 NPI # _____ SERIAL # 000001

COLLABORATING PHYSICIAN
NAME: NAME _____ LICENSE # 00000000
(Enter Address & Phone # only if different from above)
ADDRESS: STREET ADDRESS
CITY, STATE AND ZIP CODE _____ PHONE # _____ (000) 000-0000

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

Rx

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

Use separate form for each controlled substance prescription
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#4 Nurse Practitioner/
Clinical Nurse Specialist

State of New Jersey
PRESCRIPTION BLANK

NAME, ACADEMIC DEGREE & TITLE
STREET ADDRESS
CITY, STATE AND ZIP CODE
(000) 000-0000 NPI # _____
LICENSURE (RX AUTH) # _____
DEA # _____
BATCH # PRT00000000000
SERIAL # 000001

COLLABORATING PHYSICIAN
NAME: PHYSICIAN NAME _____ LICENSE #: 00000000000
TELEPHONE #: (000) 000-0000

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
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#5 Certified Nurse Midwife

State of New Jersey
PRESCRIPTION BLANK

NAME OF PRACTICE
NAME AND ACADEMIC DEGREE
IDENTIFICATION OF PROF. PRACTICE OR SPECIALTY
STREET ADDRESS
CITY, STATE AND ZIP CODE
LIC # 0000000 (000) 000-0000 BATCH # PRT00000000000
NPI # _____ SERIAL # 000001

VALID ONLY FOR PRESCRIPTION EYE WEAR

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

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

DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____
REFILL _____ TIMES

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

#6 Prescribing Eye Wear

State of New Jersey
PRESCRIPTION BLANK

PRACTICE NAME
NAME AND ACADEMIC DEGREE
SPECIALTY
STREET ADDRESS
CITY, STATE, ZIP
LIC. # 0000000 TELEPHONE NPI # _____
CERT. # _____ DE A # _____
BATCH # PRT00000000000 SERIAL # 000001

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 VALID FOR PRESCRIPTION EYEWEAR -
- VALID FOR TOPICAL PHARMACEUTICAL AGENTS AND ORAL MEDICATIONS -
- NOT VALID FOR SCHEDULE II CONTROLLED DANGEROUS SUBSTANCES -

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

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

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#7 Combo Eye Wear/TPA Certified

State of New Jersey
PRESCRIPTION BLANK

NAME AND TITLE OF PHYSICIAN ASSISTANT
NAME OF PROFESSIONAL PRACTICE
TELEPHONE # _____ LICENSE # 0000000 DEA # _____
BATCH # PRT00000000000 NPI # _____ SERIAL # 000001

NAME, DEGREE (SUPERVISING PHYSICIAN)
STREET ADDRESS
CITY, STATE ZIP
LICENSURE # _____ TELE. # _____

DELEGATED PHYSICIAN SUPERVISOR
LICENSURE # _____ TEL. # _____

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

PRT
 SPD

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

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#8 Physician Assistant