



*** 1 DOCTOR - ORDER BLANK ***
DELAWARE STANDARD FORMAT
PRESCRIPTION FORM

IF REORDER - PREV. JOB # _____ PROOF REQUESTED

ORDER DATE _____ DEALER P.O. _____ CUSTOMER P.O. _____

DEALER NAME _____ DEALER # _____ SIGNATURE _____

ADDRESS _____

SHIPPING INFORMATION: _____

STYLE

1 Part PC4-DE

- 8 Pads 16 Pads
- 24 Pads 32 Pads
- 40 Pads 48 Pads
- 64 Pads 80 Pads

2 Part PC4-DE2

- 8 Pads 16 Pads
- 24 Pads 32 Pads
- 80 Pads 120 Pads
- 160 Pads 256 Pads

Starting # _____

Landscape Portrait

Optional Copy

DOB M/F Spanish

FAMILY PRACTICE CENTER	
Physician Name, M.D.	
123 Address Way City, ST 12345 123-456-1234 Fax 123-456-5678	
LIC.# X12345 DEA# XX1234567 NPI# X123456	
Name _____	
Address _____ Date _____	
Substitution Permitted OR Substitution Permissible	
Refill NR 1 2 3 4 5	
In order for a brand name product to be dispensed, the prescriber must hand write " Brand Necessary " or " Brand Medically Necessary " in the space provided.	
BLUE BACKGROUND, REFLECTIVE WATERMARK ON BACK, SECURITY FEATURES LISTED ON BACK.	

COMPLETE INFORMATION IS REQUIRED BEFORE ORDER WILL BE ENTERED.

PRACTICE NAME _____

PHYSICIAN NAME _____

SPECIALTY _____

ADDRESS (No P.O. Box Allowed) _____

CITY _____ STATE **DE** ZIP _____

PHONE _____ FAX _____

DEA # _____ LICENSE # _____ NPI # _____

PHYSICIANS SIGNATURE _____ Security Code _____ (Or Authorized Employee)

Please provide proof

Email _____

ADDITIONAL CHARGE OPTIONS

- Pad in 50's
- Padded Wraparound Cover Stapled Wraparound Cover



***MULTI DOCTOR / MULTI ADDRESS
ORDER BLANK ***

**DELAWARE STANDARD FORMAT
PRESCRIPTION FORM**

IF REORDER - PREVIOUS JOB # _____ PROOF REQUESTED

ORDER DATE _____ DEALER P.O. _____ CUSTOMER P.O. _____

DEALER NAME _____ DEALER # _____ SIGNATURE _____

ADDRESS _____

- | | |
|---|---|
| <input type="checkbox"/> 1 Part PC4-DE | <input type="checkbox"/> 2 Part PC4-DE2 |
| <input type="checkbox"/> 8 Pads <input type="checkbox"/> 16 Pads | <input type="checkbox"/> 8 Pads <input type="checkbox"/> 16 Pads |
| <input type="checkbox"/> 24 Pads <input type="checkbox"/> 32 Pads | <input type="checkbox"/> 24 Pads <input type="checkbox"/> 32 Pads |
| <input type="checkbox"/> 40 Pads <input type="checkbox"/> 48 Pads | <input type="checkbox"/> 80 Pads <input type="checkbox"/> 120 Pads |
| <input type="checkbox"/> 64 Pads <input type="checkbox"/> 80 Pads | <input type="checkbox"/> 160 Pads <input type="checkbox"/> 256 Pads |

Start # _____

Optional Copy

- DOB M/F Spanish Label

SHIPPING INFORMATION:

PRACTICE NAME _____

DOC. 1 _____ SPECIALTY _____ Security Code _____

DEA # _____ LICENSE # _____ NPI # _____

DOC. 2 _____ SPECIALTY _____ Security Code _____

DEA # _____ LICENSE # _____ NPI # _____

DOC. 3 _____ SPECIALTY _____ Security Code _____

DEA # _____ LICENSE # _____ NPI # _____

DOC. 4 _____ SPECIALTY _____ Security Code _____

DEA # _____ LICENSE # _____ NPI # _____

ADDRESS 1 _____

CITY 1 _____ STATE 1 DE ZIP 1 _____

PHONE 1 _____ FAX 1 _____

ADDRESS 2 _____

CITY 2 _____ STATE 2 DE ZIP 2 _____

PHONE 2 _____ FAX 2 _____

ADDRESS 3 _____

CITY 3 _____ STATE 3 DE ZIP 3 _____

PHONE 3 _____ FAX 3 _____

ADDRESS 4 _____

CITY 4 _____ STATE 4 DE ZIP 4 _____

PHONE 4 _____ FAX 4 _____

Please provide proof

ADDITIONAL CHARGE OPTIONS

- Pad in 50's
- Padded Wraparound Cover Stapled Wraparound Cover

Email _____

MAXIMUM OF 5 LINES