



\* 1 DOCTOR - ORDER BLANK \*
MAINE 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-ME

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

2 Part PC4-ME2

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

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
DEA # \_\_\_\_\_
PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_
ADDRESS \_\_\_\_\_
Any drug which is the generic or chemical equivalent of the drug specified above in this prescription may be dispensed provided that the drug dispensed is listed in the current edition of either the National Formulary or the United States Pharmacopoeia and provided that no check mark (v) has been handwritten in the box in the right-hand lower corner.
Refill NR 1 2 3 4 5 Void After \_\_\_\_\_
Signature \_\_\_\_\_
Prescription is void if more than one (1) prescription is written per blank.
BLUE BACKGROUND, REFLECTIVE WATERMARK ON BACK, SECURITY FEATURES LISTED ON BACK.

PRACTICE NAME \_\_\_\_\_

PHYSICIAN NAME \_\_\_\_\_

SPECIALTY \_\_\_\_\_  Do Not Print On Form

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE ME ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

DEA # \_\_\_\_\_ LICENSE # \_\_\_\_\_ NPI # \_\_\_\_\_

PHYSICIANS SIGNATURE \_\_\_\_\_ (Or Authorized Employee)

Please provide proof

Email \_\_\_\_\_

ADDITIONAL CHARGE OPTIONS

- Imprint Part 2, Pad in 50's, Padded Wraparound Cover, Stapled Wraparound Cover



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

**MAINE STANDARD FORMAT  
PRESCRIPTION FORM**

ORDER DATE \_\_\_\_\_ DEALER P.O. \_\_\_\_\_ CUSTOMER P.O. \_\_\_\_\_

DEALER NAME \_\_\_\_\_ DEALER # \_\_\_\_\_ SIGNATURE \_\_\_\_\_

ADDRESS \_\_\_\_\_

IF REORDER - PREVIOUS JOB # \_\_\_\_\_  PROOF REQUESTED

- |   |  |                                   |                                   |
|---|--|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> <b>1 Part PC4-ME</b> | <input type="checkbox"/> <b>2 Part PC4-ME2</b> |                                   |                                   |
| <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 |

**SHIPPING INFORMATION:**

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**Optional Copy**

- DOB  M/F  Spanish Label

PRACTICE NAME \_\_\_\_\_

DOC. 1 \_\_\_\_\_ SPECIALTY \_\_\_\_\_  Do Not Print On Form

DEA # \_\_\_\_\_ LICENSE # \_\_\_\_\_ NPI # \_\_\_\_\_

DOC. 2 \_\_\_\_\_ SPECIALTY \_\_\_\_\_  Do Not Print On Form

DEA # \_\_\_\_\_ LICENSE # \_\_\_\_\_ NPI # \_\_\_\_\_

DOC. 3 \_\_\_\_\_ SPECIALTY \_\_\_\_\_  Do Not Print On Form

DEA # \_\_\_\_\_ LICENSE # \_\_\_\_\_ NPI # \_\_\_\_\_

DOC. 4 \_\_\_\_\_ SPECIALTY \_\_\_\_\_  Do Not Print On Form

DEA # \_\_\_\_\_ LICENSE # \_\_\_\_\_ NPI # \_\_\_\_\_

ADDRESS 1 \_\_\_\_\_

CITY 1 \_\_\_\_\_ STATE 1 **ME** ZIP 1 \_\_\_\_\_

PHONE 1 \_\_\_\_\_ FAX 1 \_\_\_\_\_

ADDRESS 2 \_\_\_\_\_

CITY 2 \_\_\_\_\_ STATE 2 **ME** ZIP 2 \_\_\_\_\_

PHONE 2 \_\_\_\_\_ FAX 2 \_\_\_\_\_

ADDRESS 3 \_\_\_\_\_

CITY 3 \_\_\_\_\_ STATE 3 **ME** ZIP 3 \_\_\_\_\_

PHONE 3 \_\_\_\_\_ FAX 3 \_\_\_\_\_

ADDRESS 4 \_\_\_\_\_

CITY 4 \_\_\_\_\_ STATE 4 **ME** ZIP 4 \_\_\_\_\_

PHONE 4 \_\_\_\_\_ FAX 4 \_\_\_\_\_

Please provide proof

Email \_\_\_\_\_

**OPTIONS**

- Imprint Part 2  Pad in 50's  
 Padded Wraparound Cover  Stapled Wraparound Cover

MAXIMUM OF 5 LINES