



**\* 1 DOCTOR - ORDER BLANK \***  
**NEW JERSEY STANDARD FORMAT**  
**PRESCRIPTION FORM**

If Reorder - Prev. Job # \_\_\_\_\_  Proof Requested Start # is Always #000001 (Unless same prescriber orders multiple forms in same month)  
 ORDER DATE \_\_\_\_\_ DEALER P.O. \_\_\_\_\_ CUSTOMER P.O. \_\_\_\_\_  
 DEALER NAME \_\_\_\_\_ DEALER # \_\_\_\_\_ SIGNATURE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_

- 1 PART  8 Pads  16 Pads  24 Pads  32 Pads  
 (Pads of 100)  40 Pads  48 Pads  56 Pads
- 2 PART  16 Pads  24 Pads  32 Pads  40 Pads  
 (Pads of 50)  480 Pads  112 Pads  160 Pads

- FORMAT**  Format #1  Format #2  Format #3  
 Format #4  Format #5  Format #6  Format #8

**SHIPPING INFORMATION:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

**#2 Health Care Facility**

**#3 Optometrist TPA Certified**

**#4 Nurse Practitioner/ Advanced Practice Nurse**

**#5 Certified Nurse Midwife**

**#6 Prescribing Eyewear**

**#8 Physician Assistant**

**COMPLETE THE INFORMATION BELOW BEFORE ORDER WILL BE ENTERED.**

**MAXIMUM OF 5 LINES**

PRACTICE NAME \_\_\_\_\_  
 PHYSICIAN NAME \_\_\_\_\_ SPECIALTY \_\_\_\_\_  
 ADDRESS (No P.O. Box Allowed) \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE **NJ** ZIP \_\_\_\_\_  
 PHONE \_\_\_\_\_ FAX \_\_\_\_\_  
 DEA # \_\_\_\_\_ LICENSE # \_\_\_\_\_ (Required)  
 CERTIFICATION # \_\_\_\_\_ (Required on format 3 & 4) NPI # \_\_\_\_\_  
 \*SUPERVISING PHYSICIAN REQUIRED  
 NAME \_\_\_\_\_ LICENCE #\* \_\_\_\_\_ PHONE \_\_\_\_\_  
 ADDRESS (If different from above) \_\_\_\_\_  
 PHYSICIANS SIGNATURE \_\_\_\_\_

Please provide proof

**ADDITIONAL CHARGE OPTIONS**

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

\*Required

Email \_\_\_\_\_



MULTI DOCTOR / MULTI ADDRESS ORDER BLANK \*

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ORDER DATE \_\_\_\_\_ DEALER P.O. \_\_\_\_\_ CUSTOMER P.O. \_\_\_\_\_
DEALER NAME \_\_\_\_\_ DEALER # \_\_\_\_\_ SIGNATURE \_\_\_\_\_
ADDRESS \_\_\_\_\_

- 1 PART 8 Pads 16 Pads 24 Pads 32 Pads (Pads of 100) 40 Pads 48 Pads 56 Pads
2 PART 16 Pads 24 Pads 32 Pads 40 Pads (Pads of 50) 480 Pads 112 Pads 160 Pads
FORMAT Format #1 Format #2 Format #3 Format #4 Format #5 Format #6 Format #8

SHIPPING INFORMATION:

Check box next to doctor who is the responsible party

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

DOC. 1 SPECIALTY DEA # LICENSE #\* NPI # SIGNATURE

DOC. 2 SPECIALTY DEA # LICENSE #\* NPI # SIGNATURE

DOC. 3 SPECIALTY DEA # LICENSE #\* NPI # SIGNATURE

DOC. 4 SPECIALTY DEA # LICENSE #\* NPI # SIGNATURE

ADDRESS 1 CITY 1 STATE 1 NJ ZIP 1 PHONE 1 FAX 1

ADDRESS 2 CITY 2 STATE 2 NJ ZIP 2 PHONE 2 FAX 2

ADDRESS 3 CITY 3 STATE 3 NJ ZIP 3 PHONE 3 FAX 3

Please provide proof

OPTIONS

\*Required

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

Email \_\_\_\_\_

MAXIMUM OF 6 LINES