PREMIER Rx
IN PARTNERSHIP WITH SCRIPWELL SELECT

Premier Rx Medication Evaluation Form

Full Name: _____

Address: _____

Current Pharmacy: _____

Current Pharmacy Phone Number: _____

Current Pharmacy City, State: _____

Date of Birth: _____

Medication	Dose

***Note**: Medications filled through the Premier Rx program will be provided by our specialty pharmacy partner and shipped to your home by mail (30/60/90 day supplies when available)*

I authorize the specialty pharmacy partner for Premier Rx to contact my current pharmacy and prescribing physician(s) to obtain information about my prescriptions and, if appropriate, to coordinate filling and mailing my medications through the Premier Rx program as described above. I understand this is a request for evaluation and that not all medications or situations will qualify for Premier Rx.

Member's Signature: _____ Date: _____

Please email the completed form to **ScripWellSelect@premieronetpa.com** or Fax to 260-444-4212