Rx Outreach®
The Nonprofit Pharmacy

rxoutreach.org
Join online through our website,
or call 1-888-RXO-1234 (796-1234),
or fill out this application and mail.

Step 1: Complete your Membership Application

First Name: _____ MI: _____ Last Name: _____

Date of Birth:_____/_____ / _____ Email: _____ ❒ Opt in for emails

Street Address:_____

City:_____ State:_____ Zip: _____ Phone: (_____) _____

❒ Male ❒ Female ❒ Cell ❒ Home ❒ Opt in for text messages

MEDICAL CONDITION(s) Please check all that apply

❒ Heart Disease ❒ Alzheimer's ❒ Arthritis ❒ Diabetes ❒ Cancer ❒ Other

Medication allergies (if applicable): _____

_____

Medication(s) you are currently taking: _____

_____

ELIGIBILITY

Income Information:

Annual household income: $_____ Number of people in your household, including you:_____

You must sign this form before we can send your medication(s). *I attest that the information provided in this application is complete and accurate. This authorization or a copy shall be valid for 12 months from the date of the signature. I understand that Rx Outreach reserves the right to request income verification from me or refuse my application based on any misuse, abuse or illegal distribution of any product in this program. I will not seek reimbursement of any fee I pay to Rx Outreach from my health insurance, including Medicaid, Medicare or similar programs.*

Signature Required:_____ *Date:* _____/_____/_____

(If advocate/guardian signing on behalf of patient, please complete section below)

Event Code **788**

Patient's advocate / guardian contact (if applicable) _____

Relationship: _____ Phone: (_____) _____

Scan the code using your smartphone camera app or visit the website

rxoutreach.org/find-your-medication

TO ORDER CONTROLLED SUBSTANCES, YOU MUST ATTACH A COPY OF YOUR GOVERNMENT ISSUED PHOTO ID CARD.
To protect your safety, controlled substances and expedited shipping must be signed for upon delivery.
Controlled substances are identified by (CS) on the Medication List.

You can mail in the application and prescription or fax to 1-800-875-6591.
(Faxed prescriptions must come directly from the doctor's office)

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Phone: 1-888-RXO-1234 (796-1234)
Fax: 1-800-875-6591
Hours: Mon-Fri, 7:00 am -5:30 pm CST

Step 2: Submit Your Prescription

Full Name: _____

D.O.B. _____ Phone (____) _____

☐ **Option A: Your Doctor will send prescription**

Ask your doctor to send your prescription to Rx Outreach:

1. By E-Script
2. By Phone: 1-888-796-1234
3. By Fax: 1-800-875-6591

☐ **Option B: I will mail in the Rx Outreach Membership Application and my prescription**

Rx Outreach, P.O. Box 66536
St. Louis, MO 63166-6536

☐ **Option C: Rx Outreach requests transfer from another pharmacy.**

Please list the medications that you would like transferred from another pharmacy.

_____ Pharmacy Name

( ) _____ Phone Number

( ) _____ Fax Number

_____ Doctor's Name

Medication Name	Strength	Quantity Requested

☐ **Option D: Rx Outreach requests prescription from your doctor.**

Please list the medications that you would like requested from your doctor.

_____ Doctor's Name

( ) _____ Phone Number

( ) _____ Fax Number

Medication Name	Strength	Quantity Requested

Step 3: Choose a Payment Method

Pay by Credit, Debit Card, or FSA.

_____ Cardholder's Name

_____ Credit Card Number

_____ / _____ Expiration Date (MM/YY) CVV

I authorize Rx Outreach to charge this credit card for payment on my **first** order up to $ _____

OR

Pay by check or Money Order.

☐ I will make a payment by check or money order, and mail it to:

Rx Outreach
P.O. Box 66536
St. Louis, MO 63166-6536

Over-the-Counter (OTC) Medication

No prescription needed for these medications. Please indicate all medications you would like to order on the prescription submission form. OTC orders will be applied to approved payment method. Prices subject to change.

First Name: _____ MI: _____ Last Name: _____

Date of Birth:_____/_____/ _____ Email: _____

Street Address:_____

City:_____ State:_____ Zip: _____ Phone: (_____) _____

Over the Counter Medications and Products

Product			Price	Quantity to Order
Allergies				
Budesonide Nasal Spray	32mcg	*Rhinocort® Allergy*	$22 per bottle (min. 2 bottles)	
Cetirizine Tablet	10mg	*Zyrtec®*	$10 per bottle of 100 tablets (min. 2 bottles)	
Fexofenadine Tablet	60mg	*Allegra®*	$40 per bottle of 100 tablets	
Fexofenadine Tablet	180mg	*Allegra®*	$40 per bottle of 100 tablets	
Loratadine Tablet	10mg	*Claritin®*	$10 per bottle of 100 tablets (min. 2 bottles)	
Diabetic Supplies				
Glucose Monitor (ProdigyAutocode®)			One Free Monitor Per Year* (with order of test strips)	
Glucose Control Solution Low (Prodigy®)	4mL bottle		$5 per bottle (Vial)	
Glucose No Coding Test Strips (Prodigy®)	Box of 50 strips		$15 per box	
Glucose TwistTop Lancets 28G (Prodigy®)	Box of 100 lancets		$5 per box (min. 2 boxes)	
Eye Drops				
Artificial Tears 1.4% Eye Drops	15mL bottle		$9 per bottle	
Ketotifen Ophthalmic Solution 0.025%	5mL bottle	*Zaditor®*	$9 per bottle	
Pain Relievers				
Aspirin EC Coated Tablet	325mg		$7 per bottle of 100 tablets	
Aspirin EC Coated Tablet	81mg		$9 per bottle of 120 tablets	
Capsaicin Cream 0.025%	60gm tube		$12 per tube	
Supplements				
DOK Softgel®	250mg	*Docusate Sodium*	$9 per bottle of 100 tablets	
Magnesium Oxide Tablet	400mg		$8 per bottle of 120 tablets	
Melatonin Tablet	5mg		$7 per bottle of 60 tablets (min. 2 bottles)	
Niacin SA Capsule	250mg		$9 per bottle of 100 capsules	
Vitamin B-6 Tablet	50mg		$11 per bottle of 100 tablets	
Vitamin B-6 Tablet	100mg		$7 per bottle of 100 tablets	
Vitamin D3 Capsule	50,000IU		$15 per bottle of 12 capsules	
Vitamin D3 Tablet	400IU		$11 per bottle of 100 tablets	

* restrictions apply

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