



# Providing Affordable Medications

OVER 600 MEDICATION  
STRENGTHS AVAILABLE  
THROUGH OUR MAIL-  
ORDER PHARMACY



## Follow these four simple steps...

### STEP

# 1

#### See if you qualify.

You qualify for Rx Outreach as long as your annual household income is:

- \$35,640 or less for a single person
- \$60,480 or less for a family of three
- Add \$12,420 for each additional person
- \$48,060 or less for a family of two
- \$72,900 or less for a family of four

### STEP

# 2

#### See if your medicine is on the attached Rx Outreach drug list.

Many drugs can be purchased for \$20 for a 180-day supply. The list shows the administrative fees for all drugs offered. Administrative fees shown are for any dose, any strength. So even if you take more than one pill a day, our administrative fees are still the same!

### STEP

# 3

#### Get a prescription from your doctor.

Prescriptions may be written with refills available for up to one year. Ask your doctor about a 180-day supply with one refill or a 90-day supply with three refills. Ask your doctor to e-prescribe your prescription. Rx Outreach is in the Surescripts network under NCPDP ID 2635855. Or, your physician may fax your prescription and application to 1-800-875-6591.

### STEP

# 4

#### Mail the completed application, your original prescription(s) and your payment to:

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

For more information, visit [www.rxoutreach.org](http://www.rxoutreach.org)  
or call 1-888-RXO-1234 (796-1234),  
M-F, 7:00 a.m. to 5:30 p.m. Central time.

**Rx Outreach is Not Insurance**



# RX OUTREACH APPLICATION

TO ENROLL, PLEASE FILL OUT EACH FIELD

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Date of birth: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Social Security or Green Card #: (If you do not have a SSN / Green Card, write N/A) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Circle one: Male / Female

Phone number: ( \_\_\_\_\_ ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Clinic or Physician Group (write N/A, if none): \_\_\_\_\_

Food / medications you are allergic to: \_\_\_\_\_

Other Medication you are taking and medical conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Shipping address if different from above (Your shipping address must be a deliverable U.S. Post Office street address.):

Name: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

**Income Information:** Annual household income: \$ \_\_\_\_\_ Number of people in your house, including you: \_\_\_\_\_

How did you learn about Rx Outreach?

- Doctor  Social Service Organization  Other  
 Clinic/Healthcare Facility  Self/Family

**You must sign the form before we can send your medicines.** 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 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 products 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 denote relationship and complete below)

Patient Advocate/Guardian Contact: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Event Code  
785

## IF PLACING AN ORDER

**How to Pay:** Check or money order **payable to Rx Outreach**, or credit card. Please do not send cash.

FSA/Credit card/Debit card number: \_\_\_\_\_ Expiration date: \_\_\_\_ / \_\_\_\_

- Visa  MasterCard  Discover  FSA are the only credit cards or debit cards accepted. Please check one.

**I authorize Rx Outreach to charge this credit card for payment on my first order.** Total Amount \$ \_\_\_\_\_

Name on card: \_\_\_\_\_ Cardholder Signature: \_\_\_\_\_

(required if using a credit card)

**TO ORDER CONTROLLED SUBSTANCES, YOU MUST ATTACH A COPY OF YOUR PHOTO ID CARD (for example, a driver's license or state ID card). Controlled substances and non-controlled medications will ship separately. We cannot ship controlled substances to a P.O. box or a doctor's office. (Controlled Substances are: Alprazolam, Chlordiazepoxide, Clonazepam, Dexmethylphenidate, Dextroamphetamine-Amphetamine, Dextroamphetamine-Amphetamine ER, Dextroamphetamine sulfate ER, Diazepam, Diphenoxylate/Atropine, Donnatal, Eszopiclone, Lorazepam, Modafinil, Methlyphenidate, Methylphenidate CD, Methylphenidate LA, Oxandrolone, Temazepam, Tramadol, Zaleplon, Zolpidem and Zolpidem ER).**

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)