Arkansas Prescription Order Form

Please fill out the following form and fax to Saint John Pharmacy **(318) 807-1079**

SAINT JOHN PHARMACY

Last Name: _____ First Name: _____ M. Initial: ____

Date of Birth: _____ Member ID Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____ Other: _____

Email Address: _____ SSN: _____

Allergies: _____

( ) Transfer & Mail my prescriptions using my credit card to pay any and all charges

You can call Saint John Pharmacy at (888) 316-4354 with your prescription information to transfer your medications. We can charge your debit or credit card for the applicable copay and shipping charges. **Shipping is free for Vantage Members.** Please allow 48 hours to transfer and process the prescription(s) and an additional 4-5 days for the U.S. Postal Service to deliver. No controlled substances, refrigerated items, or acute medications can be mailed.

Medication Name: _____ Prescription Number: _____

Pharmacy Name and Phone Number: _____

Medication Name: _____ Prescription Number: _____

Pharmacy Name and Phone Number: ☐ Same _____

Medication Name: _____ Prescription Number: _____

Pharmacy Name and Phone Number: _____

Medication Name: _____ Prescription Number: _____

Pharmacy Name and Phone Number: ☐ Same _____

Medication Name: _____ Prescription Number: _____

Pharmacy Name and Phone Number: _____

If you have more prescriptions, please use the back of this page or attach another page with the information on each.

☐ **Check here if you prefer the less expensive generic equivalent drug, if available, for the brand prescribed.**

Billing Information

Payment Type: ☐ Visa® ☐ MasterCard® ☐ Discover® ☐ American Express®

Credit Card Number: _____ Expiration Date: _____

By signing below, I authorize Saint John Pharmacy to use the credit card information listed to provide payment on any outstanding balance.

Cardholder Signature X _____

Date: _____

AFFINITY HEALTH GROUP