



Prescription Order Form

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

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: _____

Prescription Information: Please check to indicate your choice:

Transfer below prescriptions and I will pick up at Saint John Pharmacy

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 2-3 days for the U.S. Postal Service to deliver. Prescription auto-fill is available upon request.

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.

Billing Information

Circle credit card type or include a copy: 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: _____

