State of New Jersey

PRESCRIPTION BLANK

FACILITY NAME

STREET

CITY STATE ZIP

PHONE

PRINT: _____

NAME AND TITLE OF PRESCRIBER AND, IF APPLICABLE, COLLABORATIVE PHYSICIAN

LICENSE # _____ NPI # _____

CHECK IF: ❑ APN ❑ CNM ❑ PA

LICENSE / CERTIFICATE / Rx AUTHORIZATION #

_____

DEA # PRESCRIBER: _____

COLLABORATIVE PHYS: _____

PATIENT _____ D.O.B. _____

ADDRESS _____ DATE _____

Rx

IF ISSUED BY AN OPTOMETRIST, NOT VALID FOR SCHEDULE II CONTROLLED DANGEROUS SUBSTANCES, EXCEPT FOR HYDROCODONE-CONTAINING PRODUCTS

WL000000000000

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____

DO NOT REFILL _____

REFILL _____ TIMES

SIGNATURE OF PRESCRIBER

Use a separate form for each controlled substance prescription

THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW