State of New Jersey

PRESCRIPTION BLANK

NAME AND TITLE OF PHYSICIAN ASSISTANT

NAME OF PROFESSIONAL PRACTICE

TELEPHONE #

NPI # _____

LICENSE # _____ DEA # _____

NAME, DEGREE (SUPERVISING PHYSICIAN)

ADDRESS CITY, STATE ZIP PHONE

LICENSE # _____ DEA # _____

❑ DELEGATED PHYSICIAN SUPERVISOR _____

LICENSE # _____ TEL # _____

IF PRESCRIPTION IS WRITTEN AT ALTERNATE PRACTICE SITE, CHECK HERE ❑
AND PRINT ALTERNATE ADDRESS AND TELEPHONE NUMBER ON REVERSE SIDE

PATIENT _____ D.O.B. _____

ADDRESS _____ DATE _____

Rx

❑ PRT

❑ SPD

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____

DO NOT REFILL _____

REFILL _____ TIMES

SIGNATURE OF PRESCRIBER

Use a separate form for each controlled substance prescription

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