

PRESCRIPTION PADS

RED = MUST • **BLUE = RECOMMENDED**

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # AND DEA # AND ACSC#

PATIENT NAME _____ DATE _____

ADDRESS _____

ALABAMA

- Recommended to have DEA and LIC # and Alabama Controlled Sub. #
- Recommended to have physician/practice name, address
- Must have signature lines at bottom
- Must have Dispense as Written & Substitution Permitted listed on script location doesn't matter

☐ LABEL

Refill NR 1 2 3 4 5

DISPENSE AS WRITTEN **PRODUCT SELECTION PERMITTED**

Rx
FACES WITH HEAT

PHARM-00-00

PHYSICIAN'S NAME 1234567
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
NPI # 1234567890

PATIENT NAME _____ DATE _____

ADDRESS _____

ALASKA

- No recommendations on format
- Medicaid scripts must have NPI # printed on pad
- Medicaid scripts must have consecutive numbering
- Physician Assistant need supervising physician name on Rx

Any drug which is the generic or chemical equivalent of the drug specified above in this prescription may be dispensed provided that the drug dispensed is listed in the current edition of either the National Formulary or the United States Pharmacopoeia and provided that no check mark (✓) has been handwritten in the box in the right-hand lower corner. ☐

Refill NR 1 2 3 4 5 Void After _____

Signature _____

Prescription is void if more than one (1) prescription is written per blank.

Rx
FACES WITH HEAT

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000

PATIENT NAME _____ DATE _____

ADDRESS _____

ARIZONA

- No recommendations on format
- Medicaid scripts must be on secure Rx paper
- Meet CMS guidelines

Any drug which is the generic or chemical equivalent of the drug specified above in this prescription may be dispensed provided that the drug dispensed is listed in the current edition of either the National Formulary or the United States Pharmacopoeia and provided that no check mark (✓) has been handwritten in the box in the right-hand lower corner. ☐

Refill NR 1 2 3 4 5 Void After _____

Signature _____

Prescription is void if more than one (1) prescription is written per blank.

Rx
FACES WITH HEAT

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000

PATIENT NAME _____ DATE _____

ADDRESS _____

ARKANSAS

- No recommendations on format

Any drug which is the generic or chemical equivalent of the drug specified above in this prescription may be dispensed provided that the drug dispensed is listed in the current edition of either the National Formulary or the United States Pharmacopoeia and provided that no check mark (✓) has been handwritten in the box in the right-hand lower corner. ☐

Refill NR 1 2 3 4 5 Void After _____

Signature _____

Prescription is void if more than one (1) prescription is written per blank.

Rx
FACES WITH HEAT

04-16-20

PHYSICIAN'S NAME, M.D. 000001
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000
DEA# XX00000
19301102214

PATIENT NAME _____ GENDER _____

ADDRESS _____

CALIFORNIA SINGLE

- Must have boxes for multiple doctors check-off
- Must have credentials behind each doctor's name
- Must have barcode serial number, consecutive & batch numbering
- Must imprint License & DEA #'s on all scripts
- Must have security printer id # on Rx - Wilmer # is SP98
- Laser Rx, we must have Check box for Do not substitute, Date field, Check boxes for number of refills, Prescription is void etc.. with box or fill in blank

Quantity: ☐ 1-24 ☐ 25-49 ☐ 50-74 ☐ 75-100
Refills: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Signature _____ Date _____

Prescription is void if the number of drugs prescribed is not noted. Number of Drugs _____

Rx
FACES WITH HEAT

Serial # WCCZ389A00001

BLUE BACKGROUND, REFLECTIVE WATERMARK ON BACK.

04-16-20

PHYSICIAN'S NAME, MD (ETC) 000001
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000
DEA# XX00000
19301102214

PATIENT NAME _____ GENDER _____

ADDRESS _____

CALIFORNIA MULTIPLE

- Must have boxes for multiple doctors check-off
- Must have credentials behind each doctor's name
- Must have barcode serial number, consecutive & batch numbering
- Must imprint License & DEA #'s on all scripts
- Must have security printer id # on Rx - Wilmer # is SP98
- Laser Rx, we must have Check box for Do not substitute, Date field, Check boxes for number of refills, Prescription is void etc.. with box or fill in blank

Quantity: ☐ 1-24 ☐ 25-49 ☐ 50-74 ☐ 75-100
Refills: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Signature _____ Date _____

Prescription is void if the number of drugs prescribed is not noted. Number of Drugs _____

Rx
FACES WITH HEAT

Serial # WCCZ389A00001

BLUE BACKGROUND, REFLECTIVE WATERMARK ON BACK.

PRESCRIPTION PADS

09-10-18

RED = MUST • **BLUE = RECOMMENDED**

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

NAME _____ DATE _____

ADDRESS _____

COLORADO

- No recommendations on format
- Okay to preprint controlled substances on Rx
- Must have Dispense as Written OR Do Not Substitute

☐ Dispense As Written

Signature _____

PLUS RED IMAGE
Rx
FACES WITH HEAT

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

Patient Name _____

Address _____ Date _____

CONNECTICUT

- No recommendations on format

☐ LABEL

Refill _____ Times PRN NR

Signature _____

PLUS RED IMAGE
Rx
FACES WITH HEAT

PHYSICIAN'S NAME 00001
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

Name _____

Address _____ Date _____

DELAWARE

- Must always have a blue background
- Must have license number imprinted
- Must be consecutive numbered from order to order
- Must have two signature lines, side by side or stacked
- Must have a refill indicator with any amount of numbers
- Must have "Substitution Permitted OR Substitution Permissible" & Must In order for
- Only 1 controlled substance preprinted per script, if preprinted, qty. of drug must be in number & text format

Substitution Permitted OR Substitution Permissible

Refill NR 1 2 3 4 5

In order for a brand name product to be dispensed, the prescriber must hand write "Brand Necessary" or "Brand Medically Necessary" in the space provided.

PH0212-14-05

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

Patient Name _____

Address _____ Date _____

WASHINGTON DC

- No recommendations on format

☐ LABEL

Refill _____ Times PRN NR

Signature _____

PLUS RED IMAGE
Rx
FACES WITH HEAT

09-10-18

PHYSICIAN'S NAME, MD WIL0602200001
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
DEA # or DEA # _____

☐ NONACUTE PAIN ☐ ACUTE PAIN EXCEPTION

FLORIDA

- No recommendations on format
- Must have 3 letter approved prefix with batch #
- DEA # or DEA _____ must be on script
- Controlled substance scripts must have MD or Facility name, address and licensure category imprinted unless computer generated
- LIC# must still be given to verify, but we don't have to imprint the LIC#
- No restrictions on pre-printing substances on pad
- ARNP & CNS must be changed to APRN

☐ LABEL

Refill _____ Times PRN NR

TO INSURE BRAND NAME DISPENSING, PRESCRIBER MUST WRITE "MEDICALLY NECESSARY" ON THE PRESCRIPTION.

PLUS RED IMAGE
Rx
FACES WITH HEAT

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000

Patient Name _____

Address _____ Date _____

GEORGIA

- No recommendations on format
- Effected 7/1/13 Meet CMS requirements,
- Must be on secure paper

☐ LABEL

Refill _____ Times PRN NR

TO INSURE BRAND NAME DISPENSING, PRESCRIBER MUST WRITE "MEDICALLY NECESSARY" ON THE PRESCRIPTION.

PLUS RED IMAGE
Rx
FACES WITH HEAT

PRESCRIPTION PADS

RED = MUST • BLUE = RECOMMENDED

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

Name _____ Age _____

Address _____ Date _____

HAWAII

• No recommendations on format

Refill _____ Times

(Signature) _____

To ensure brand name dispensing, practitioner must handwrite "Do Not Substitute, Brand Medically Necessary" on the prescription.

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

NAME _____ DATE _____

ADDRESS _____

IDAHO

• Check box with Dispense as Written is recommended

☐ Dispense As Written

Signature _____

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

NAME _____ DATE _____

ADDRESS _____

ILLINOIS

• Must have May Not Substitute and Signature line

• Cannot preprint Controlled Substance on script

REFILL _____ TIMES

Signature _____

☐ MAY SUBSTITUTE ☐ MAY NOT SUBSTITUTE

If logo is needed must fit in this area

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
LIC. # or LIC. _____

Nothing can print in this area

INDIANA

Name: _____

Address: _____ Date: _____

• Approved format must be used

• 1" logo box at top left try to keep imprint out of this area but if needed can run in this area

• knockout Rx on right do not let imprint run into this area

• Cannot preprint any type of drugs on script

• Script must be 5.5" wide by 4.25" tall

Refill NR 1 2 3 4 5 Void after: _____

☐ 1-24
☐ 25-49
☐ 50-74
☐ 75-100
☐ 101-150
☐ 151 and over

Dispense as Written _____ May Substitute _____

Prescription is void if more than one (1) prescription is written per blank.

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

Patient Name _____

Address _____ Date _____

IOWA

• No recommendations on format

☐ LABEL

Refill _____ Times PRN NR

Signature _____

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

PATIENT NAME _____

ADDRESS _____ DATE _____

KANSAS

• Signature lines at bottom are recommended

• Dispense As Written is on the left, and Brand Exchange Permissible on the right

☐ LABEL

Refill NR 1 2 3 4 5

DISPENSE AS WRITTEN _____ BRAND EXCHANGE PERMISSIBLE _____

PRESCRIPTION PADS

RED = MUST



BLUE = RECOMMENDED

If logo is needed must fit in this area text can appear in this area if no logo is needed.

FAMILY PRACTICE CENTER

☐ Physician Name
Address
Phone
DEA#
License #

☐ Physician Name
Address
Phone
DEA#
License #

NO TEXT ON TOP OF THE RX

NUMBERING CAN BE PLACED HERE

PATIENT NAME _____ DATE _____

ADDRESS _____

KENTUCKY

- Approved format must be used
- Must imprint DEA # or DEA _____
- 1" logo box at top left corner
- Cannot preprint controlled substance on script
- Script must be 5.5" wide by 4.25" tall
- Numbering CAN print on top of RX

Initial Quantity
☐ 1-24
☐ 25-49
☐ 75-100
☐ 101-150
☐ 151 and over

Refill NR 1 2 3 4 5

Signature _____

Prescription is void if more than one (1) prescription is written per blank.

Rx
FACES WITH HEAT

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

NAME _____ DATE _____

ADDRESS _____

LOUISIANA

- Must have A check off box with Dispense as written & refill with a line
- Only 1 Signature is allowed on script
- No restrictions on preprinting controlled substances
- No more than 4 drugs per prescription (in case we preprint)
- Medicaid/Medicare must **handwrite** "brand necessary" or "brand medically necessary" on script.

☐ Dispense As Written

Refills _____

Signature _____

Rx
FACES WITH HEAT

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000

DEA # or DEA # _____

PATIENT NAME _____ DATE _____

ADDRESS _____

MAINE

- If no sample, use approved format.
- Must imprint DEA # or DEA # _____
- Must always order horizontal script, unless distributor provides a waiver from state dept. to produce a vertical script
- Can be blue or green

Any drug which is the generic or chemical equivalent of the drug specified above in this prescription may be dispensed provided that the drug dispensed is listed in the current edition of either the National Formulary or the United States Pharmacopoeia and provided that no check mark (✓) has been handwritten in the box in the right-hand lower corner.

Refill NR 1 2 3 4 5 Void After _____

Signature _____

Prescription is void if more than one (1) prescription is written per blank.

Rx
FACES WITH HEAT

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

PATIENT NAME _____ DATE _____

ADDRESS _____

MARYLAND

- No recommendations on format
- Cannot preprint controlled substance on Rx
- Cannot preprint name & address of pharmacy or pharmacist

☐ LABEL

Refill NR 1 2 3 4 5

Signature _____

Rx
FACES WITH HEAT

04-27-18

PHYSICIANS NAME
Address Line 1
Address Line 2
Address Line 3

Name _____ Age _____

Address _____

MASSACHUSETTS

- Signature line is required
- Verbiage "Interchange is.." must be printed in space under signature line
- If Rx is for clinic or hospital, must have a line to print or type MD's name under signature line
- Refill must be imprinted but doesn't need to be this format
- Vets must follow these guidelines

Refill _____ Times

Signature _____

Interchange is mandated unless the practitioner indicates "NO SUBSTITUTION" in accordance with the law.

Rx
FACES WITH HEAT

PHYSICIANS NAME
Address Line 1
Address Line 2
Address Line 3

Name _____ Age _____

Address _____

MICHIGAN

- No recommendations on format
- May preprint 6 controlled or 6 non-controlled substances on script
- Cannot imprint controlled & non-controlled substances on same script

☐ LABEL

Refill _____ Times

DEA # _____

Signature _____

Rx
FACES WITH HEAT

PRESCRIPTION PADS

04-27-18

RED = MUST • **BLUE = RECOMMENDED**

04-26-18

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

Patient Name _____

Address _____ Date _____

MINNESOTA

- No recommendations on format
-

☐ LABEL

Refill _____ Times PRN NR

Signature _____



PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

PATIENT NAME _____

ADDRESS _____ DATE _____

MISSISSIPPI

- Signature lines at bottom are recommended
- Dispense As Written is on the left, and Substitution Permitted on the right

☐ LABEL

Refill NR 1 2 3 4 5

DISPENSE AS WRITTEN SUBSTITUTION PERMITTED



PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

PATIENT NAME _____

ADDRESS _____ DATE _____

MISSOURI

- Must have two signature lines
- Substitution Permitted is on the left, and Dispense As Written is on the right

☐ LABEL

Refill NR 1 2 3 4 5

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN



PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # 000000

PATIENT NAME _____ DATE _____

ADDRESS _____

MONTANA

- No recommendations on format

Any drug which is the generic or chemical equivalent of the drug specified above in this prescription may be dispensed provided that the drug dispensed is listed in the current edition of either the National Formulary or the United States Pharmacopoeia and provided that no check mark (✓) has been handwritten in the box in the right-hand lower corner.

Refill NR 1 2 3 4 5 Void After _____

Signature _____

Prescription is void if more than one (1) prescription is written per blank.



PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

Patient Name _____

Address _____ Date _____

NEBRASKA

- No recommendations on format

☐ LABEL

Refill _____ Times PRN NR

Signature _____



PHYSICIAN'S NAME, M.D.
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000

DEA # XXXXXX OR _____ • Lic. # X00000 OR _____

NAME _____ DATE _____

ADDRESS _____ DOB _____

ICD-10 Diagnosis _____ NEVADA

This prescription provides _____ (number of days) _____ days of medication

- Approved format recommended for controlled substance
- ICD-10 diagnosis code & This prescription is recommended
- Check box with Dispense as Written is recommended

Initial Quantity

1-24

25-49

50-74

75-100

101-150

151 and over

☐ Dispense As Written

Signature _____



PRESCRIPTION PADS**RED = MUST****BLUE = RECOMMENDED****PHYSICIAN'S NAME**

123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # 000000

PATIENT NAME _____ DATE _____

ADDRESS _____

NEW HAMPSHIRE

- No recommendations on format

Any drug which is the generic or chemical equivalent of the drug specified above in this prescription may be dispensed provided that the drug dispensed is listed in the current edition of either the National Formulary or the United States Pharmacopoeia and provided that no check mark (✓) has been handwritten in the box in the right-hand lower corner.



Refill NR 1 2 3 4 5 Void After _____

Signature _____

Prescription is void if more than one (1) prescription is written per blank.



PPH#00-000

NEW JERSEY

**WE HAVE APPROVAL
TO DO NEW JERSEY PRESCRIPTIONS
Refer to New Jersey files**

PHYSICIAN'S NAME

123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # 000000

PATIENT NAME _____ DATE _____

ADDRESS _____

NEW MEXICO

- No recommendations on format
- Can print controlled and non controlled substance on script

Any drug which is the generic or chemical equivalent of the drug specified above in this prescription may be dispensed provided that the drug dispensed is listed in the current edition of either the National Formulary or the United States Pharmacopoeia and provided that no check mark (✓) has been handwritten in the box in the right-hand lower corner.



Refill NR 1 2 3 4 5 Void After _____

Signature _____

Prescription is void if more than one (1) prescription is written per blank.



PPH#00-000

NEW YORK

**WE DO NOT HAVE APPROVAL
TO DO NEW YORK PRESCRIPTIONS**

If logo is needed
must fit in this area

PHYSICIAN'S NAME

123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

PATIENT NAME _____ DATE _____

ADDRESS _____

NORTH CAROLINA

- May have 2 signatures lines at the bottom or 1 sig line with check boxes for PSP and DAW
- If using 2 sig lines, Product Selection Permitted is on the left, and Dispense As Written is on the right
- Cannot preprint controlled substances on script
- 1" logo box at top left corner

☐ LABEL

Refill NR 1 2 3 4 5

PRODUCT SELECTION PERMITTED

DISPENSE AS WRITTEN



PPH#00-000

PHYSICIAN'S NAME

123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # 000000

PATIENT NAME _____ DATE _____

ADDRESS _____

NORTH DAKOTA

- No recommendations on format

Any drug which is the generic or chemical equivalent of the drug specified above in this prescription may be dispensed provided that the drug dispensed is listed in the current edition of either the National Formulary or the United States Pharmacopoeia and provided that no check mark (✓) has been handwritten in the box in the right-hand lower corner.



Refill NR 1 2 3 4 5 Void After _____

Signature _____

Prescription is void if more than one (1) prescription is written per blank.



PPH#00-000

PRESCRIPTION PADS

04-16-20

RED = MUST • **BLUE = RECOMMENDED**

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

NAME _____ DATE _____

ADDRESS _____ **OHIO**

- Name _____ , Address _____ , and Refill with numerals are recommended.
- Allowed to preprint 3 non-controlled substances on Rx
- Allowed to preprint 1 controlled substance on Rx
- Cannot mix non-controlled & controlled on same Rx

Refill 1 2 3 4 5

Signature _____

RUB RED IMAGE
FACES WITH HEAT

PPH1042-00-00

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

Patient Name _____

Address _____ **OKLAHOMA** Date _____

- No recommendations on format
- Only one (1) preprinted drug per script

☐ LABEL

Refill _____ Times PRN NR

Signature _____

RUB RED IMAGE
FACES WITH HEAT

PPH1042-00-00

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # 000000

PATIENT NAME _____ DATE _____

ADDRESS _____ **OREGON**

- **We cannot imprint the DEA# or controlled substances on scripts for dentist**
- No recommendations on format
- May imprint controlled & non-controlled drugs
- May mix controlled & non-controlled drugs on the same script

Any drug which is the generic or chemical equivalent of the drug specified above in this prescription may be dispensed provided that the drug dispensed is listed in the current edition of either the National Formulary or the United States Pharmacopoeia and provided that no check mark (✓) has been handwritten in the box in the right-hand lower corner.

Refill NR 1 2 3 4 5 Void After _____

Signature _____

RUB RED IMAGE
FACES WITH HEAT

PPH1042-00-00

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # XX0000
DEA # _____
Do not imprint actual DEA number

NAME _____ DATE _____

ADDRESS _____ **PENNSYLVANIA**

- Bottom paragraph (SUBSTITUTION PERMISSIBLE - IN ORDER...with a line) in 8 point upper case type is required.
- Cannot print controlled substances on pad.

SIGNATURE _____

SUBSTITUTION PERMISSIBLE IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY" or "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW.

RUB RED IMAGE
FACES WITH HEAT

PPH1042-06-10

04-19

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

NAME _____ DATE _____

ADDRESS _____ **RHODE ISLAND**

- Signature with a line is recommended

Refill 1 2 3 4 5

Signature _____

RUB RED IMAGE
FACES WITH HEAT

PPH1042-00-07

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

PATIENT NAME _____

ADDRESS _____ **SOUTH CAROLINA** DATE _____

- Signature lines at bottom are required on ALL scripts
- Dispense As Written is on the left, and Substitution Permitted on the right
- All schedule II, III, IV & V must be on tamper resistant paper

☐ LABEL

Refill NR 1 2 3 4 5

DISPENSE AS WRITTEN SUBSTITUTION PERMITTED

RUB RED IMAGE
FACES WITH HEAT

PPH1042-00-00

06-18

PRESCRIPTION PADS

RED = MUST



BLUE = RECOMMENDED

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # 000000

PATIENT NAME _____ DATE _____

ADDRESS _____

SOUTH DAKOTA

- No recommendations on format

Any drug which is the generic or chemical equivalent of the drug specified above in this prescription may be dispensed provided that the drug dispensed is listed in the current edition of either the National Formulary or the United States Pharmacopoeia and provided that no check mark (✓) has been handwritten in the box in the right-hand lower corner. ☐

Refill NR 1 2 3 4 5 Void After _____

Signature _____

Prescription is void if more than one (1) prescription is written per blank.

Rx
FACES WITH HEAT

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

PATIENT NAME _____ DATE _____

ADDRESS _____

TENNESSEE

- Signature lines at bottom are recommended
- Dispense As Written is on the left, and Substitution Allowed on the right
- No regulations on preprinting of controlled or non-controlled substances
- All prescriptions must be on secure paper including non-controlled

☐ LABEL

Refill NR 1 2 3 4 5

DISPENSE AS WRITTEN SUBSTITUTION ALLOWED

Rx
FACES WITH HEAT

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
DEA #XX##### or DEA # _____

Name _____ Age _____

Address _____ Date _____

TEXAS

Not to be used for schedule II controlled substances

- Scripts for Schedule II drugs must be printed/purchased through BOP.
- May preprint more than one Schedule III-IV controlled substance or non-controlled substance on Rx
- Recommended to print DEA # or DEA # _____ if used for controlled substances, must be on script before going to pharmacy

Refill _____ times

☐ Label

(Signature)

A generically equivalent drug product may be dispensed unless the practitioner hand writes the words "Brand Necessary" or "Brand Medically Necessary" on the face of the prescription.

Rx
FACES WITH HEAT

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # 000000

PATIENT NAME _____ DATE _____

ADDRESS _____

UTAH

- No recommendations on format

Any drug which is the generic or chemical equivalent of the drug specified above in this prescription may be dispensed provided that the drug dispensed is listed in the current edition of either the National Formulary or the United States Pharmacopoeia and provided that no check mark (✓) has been handwritten in the box in the right-hand lower corner. ☐

Refill NR 1 2 3 4 5 Void After _____

Signature _____

Prescription is void if more than one (1) prescription is written per blank.

Rx
FACES WITH HEAT

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

NAME _____ DATE _____

ADDRESS _____

VERMONT

- No recommendations on format

Refill 1 2 3 4 5

Signature _____

Rx
FACES WITH HEAT

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Lic. # X00000

PATIENT NAME _____ AGE _____

ADDRESS _____ DATE _____

VIRGINIA

- No recommendations on format
- Allow to preprint Schedule VI (non-controlled) drugs
- Cannot preprint Schedule II - V

Refill _____ times

☐ LABEL

☐ BRAND MEDICALLY NECESSARY

(Signature)

To ensure brand name dispensing, check box.

Rx
FACES WITH HEAT

PRESCRIPTION PADS

RED = MUST • **BLUE = RECOMMENDED**

PHYSICIAN'S NAME 123 Physicians Way Anytown, U.S.A. 12345 000-000-0000 Lic. # X00000	
PATIENT NAME _____	DATE _____
ADDRESS _____	DOB _____
WASHINGTON	
<ul style="list-style-type: none"> Must have signature lines at bottom Substitution Permitted must be on the left Dispense as Written must be on the right Bowl must always be in bottom right hand corner All prescription must be on secure paper (even non-controlled) 	
<div style="display: flex; justify-content: space-between;"> <div> Quantity <input type="checkbox"/> 1-24 <input type="checkbox"/> 25-49 <input type="checkbox"/> 50-74 <input type="checkbox"/> 75-100 <input type="checkbox"/> 101-150 <input type="checkbox"/> 151 and over </div> <div> Unit _____ Refills: 0 - 1 - 2 - 3 - 4 - 5 </div> </div>	
<div style="display: flex; justify-content: space-around;"> SUBSTITUTION PERMITTED DISPENSE AS WRITTEN </div>	

PHYSICIAN'S NAME 123 Physicians Way Anytown, U.S.A. 12345 000-000-0000 Lic. # X00000		Rx
PATIENT NAME _____ DATE _____		
ADDRESS _____		
WEST VIRGINIA		
<ul style="list-style-type: none"> Approved format must be used 		
<div style="display: flex; justify-content: space-between;"> <div> Refill NR 1 2 3 4 </div> <div> <input type="checkbox"/> 1-24 <input type="checkbox"/> 25-49 <input type="checkbox"/> 50-74 <input type="checkbox"/> 75-100 <input type="checkbox"/> 101-150 <input type="checkbox"/> 151 and over </div> </div>		
Signature _____ Prescription is void if more than one (1) prescription is written per blank.		
<small>THIS PRESCRIPTION MAY BE FILLED WITH A GENERICALLY EQUIVALENT DRUG PRODUCT UNLESS THE WORDS "BRAND MEDICALLY NECESSARY" ARE WRITTEN, IN THE PRACTITIONER'S OWN HANDWRITING, ON THIS PRESCRIPTION FORM.</small>		

PHYSICIAN'S NAME 123 Physicians Way Anytown, U.S.A. 12345 000-000-0000 Lic. # X00000	
PATIENT NAME _____	
ADDRESS _____ DATE _____	
WISCONSIN	
<ul style="list-style-type: none"> No recommendations on format 	
<input type="checkbox"/> LABEL Refill NR 1 2 3 4 5	
Signature _____	

PHYSICIAN'S NAME 123 Physicians Way Anytown, U.S.A. 12345 000-000-0000 Lic. # 000000	
PATIENT NAME _____ DATE _____	
ADDRESS _____	
WYOMING	
<ul style="list-style-type: none"> Must have refill indicator and Quantity check off boxes 	
<small>Any drug which is the generic or chemical equivalent of the drug specified above in this prescription may be dispensed provided that the drug dispensed is listed in the current edition of either the National Formulary or the United States Pharmacopoeia and provided that no check mark (✓) has been handwritten in the box in the right-hand lower corner.</small>	
Refill NR 1 2 3 4 5 Void After _____	
Signature _____ Prescription is void if more than one (1) prescription is written per blank.	

PHYSICIAN'S NAME 123 Physicians Way Anytown, U.S.A. 12345 000-000-0000 Lic. # X00000	
PATIENT NAME _____	
ADDRESS _____ DATE _____	
Puerto Rico	
<ul style="list-style-type: none"> No recommendations on format Follow USA's CMS Guidelines 	
<input type="checkbox"/> LABEL Refill NR 1 2 3 4 5	
Signature _____	

Rx		Prescriber's Name _____ Address _____ Tel No. _____ Prescriber's Reg. No. _____	
Date _____			
PATIENT INFORMATION			
Name	Health Insurance	Yes	No
Address	Telephone No.	() ()	() ()
Height (m)	Patient's ID No.		
Weight (kg)			
ICD 10 Code			
PRESCRIPTIONS			
• 5 1/2 (L) x 8 1/2 (W) • White Paper • Black Ink			
Repeat	(None)	(1)	(2)
	(3)	(4)	(5)
	(6)	(7)	(8)
ADDITIONAL PRESCRIBER'S INFORMATION			
Name (Block Letters)		OR	
Signature		PLACE PRESCRIBER'S OFFICIAL STAMP HERE	
PHARMACIST INFORMATION			
Name (Block Letters) or Stamp			
Pharmacist Reg. No.		Signature	

PRESCRIPTION PADS

RED = MUST • BLUE = RECOMMENDED

PPH#0000

PHYSICIAN'S NAME
123 Physicians Way
Anytown, U.S.A. 12345
000-000-0000
Registration # X00000

PATIENT NAME _____

ADDRESS _____ DATE _____

JAMAICA

HEALTH RECORDS # _____

- Must have Physician name, address & Reg. #
- Approved Format
- Must have signature lines at bottom

Signature _____