CompleteCaRe Pharmacy Rx

Hours of Operation: 8AM–6PM EST | Phone: 877.854.3060
Fax: 877.788.4942 | E-Scribe (NCPDP/NAPB): 1487582

True. Blue.

Mitigare® (colchicine) Capsules

West-Ward Home Delivery

Please fill in the prescription information below

Date: ____________________ Mitigare (Colchicine) 0.6 MG Capsules

Quantity: ____________________ Sig: ____________________ Refills: ____________________

Prescriber Signature: ____________________

Patient Information

Name: ____________________ Date of Birth: ____________________

Address: ____________________ City: ____________________ State: ____________________ Zip: ____________________

Cell Phone: ____________________ Email: ____________________

Major Health Conditions: ____________________ Drug Allergies: ____________________

Prescriber Information

Prescriber Name: ____________________ Prescriber NPI : ____________________

Prescriber Address: ____________________ City: ____________________ State: ____________________ Zip: ____________________

Prescriber Phone: ____________________ Prescriber Fax: ____________________

Prescriber DEA ____________________

Insurance Information

Insurance Company Name: ____________________ Insured ID/Policy# ____________________

Rx PCN: ____________________ Rx BIN# ____________________ Rx Group ____________________

By signing this form, I authorize the above prescriber to share the above information with CompleteCare Rx Pharmacy for the purpose of filling this prescription. I understand that CompleteCare Rx Pharmacy will not use my information for any other purpose. I further understand that CompleteCare may share my personal information with its service providers and business partners for the purpose of filling this prescription. I understand that CompleteCare maintains reasonable physical, administrative, and technical safeguards to protect my personal information against unauthorized disclosure, use, alteration, or destruction, and requires the third-party service providers and business partners that it works with to do the same.

Patient Signature ____________________ Date: ____________________

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