CANAMERICA*Plus*
America's Mail Order Drugstore Since 2002

CASH PAYER ORDER FORM

FAX: 1–866–548–8621
CALL: 1–888–788–1112

PRESCRIBER

PRESCRIBER SIGNATURE | DATE

FULL NAME | STREET ADDRESS | CITY

STATE | ZIP | NPI # | LICENSE # | PHONE | FAX

☑ Yes, please contact the patient named below in regards to ordering this prescription.

PATIENT

FIRST NAME | LAST NAME | DRUG ALLERGIES

STREET ADDRESS | CITY | STATE | ZIP CODE

PRIMARY PHONE | ☐ CELL PHONE ☐ LAND LINE | WEIGHT (lbs) | SEX | DATE OF BIRTH | SMOKER?

New therapy? ☐ YES ☐ NO Reason for therapy: ☐ DIABETES ☐ WEIGHT LOSS Ship to: ☐ PATIENT ☐ PRESCRIBER

RX Complete below or use your own prescription pad.

☐ **OZEMPIC** FILL: _____ PENS REFILLS: _____
☐ 2MG (2MG/1.5ML) ☐ 4MG (4MG/3ML)

☐ **SAXENDA 6MG/ML** FILL: _____ PENS REFILLS: _____

☐ **RYBELSUS** FILL: _____ TABS REFILLS: _____
☐ 3MG ☐ 7MG ☐ 14MG

☐ **ELIQUIS** FILL: _____ TABS REFILLS: _____
☐ 2.5MG ☐ 5MG

☐ **OTHER (below)** FILL: _____ REFILLS: _____

DIRECTIONS FOR USE

Delivered *Directly* To Patients