

Medication Request

Customer Service: 1-877-453-4566 Fax Order Submission: 1-866-537-0877

Walmart 
Specialty Pharmacy

UPON RECEIPT OF THIS FORM, WALMART SPECIALTY PHARMACY WILL VERIFY BENEFITS AND CONTACT MEMBERS BY TELEPHONE TO CONFIRM DELIVERY OF COVERED PRESCRIPTIONS. IT IS ESSENTIAL THAT A WALMART SPECIALTY PHARMACY REPRESENTATIVE MAKE CONTACT WITH THE MEMBER IN ORDER TO ENSURE DELIVERY TO THE PATIENT'S HOME WITHIN 24-48 HOURS.

100 Technology Park
Suite 155
Lake Mary, FL 32746
Hours of Operation
Monday-Friday: 9:00am-9:00pm EST
Saturday: 9:00am-3:00pm EST
Sunday: Closed

Today's Date:

Date Needed:

Section I - Patient Information

First Name: Last Name: Date of Birth: Height: Weight:

Address: City: State: ZIP Code:

Home Phone: Work Phone: Cell Phone: Email Address:

Allergies:

Questions/Comments:

Section II - Insurance Information

Primary Insurance: Policy Number: Group Number:

Pharmacy Benefit Manager (PBM): Insured Cardholder: Phone:

Medicare? Yes No If Yes, provide #: Medicaid? Yes No If Yes, provide #:

Secondary Insurance: Policy Number: Group Number:

Insured Cardholder: Phone:

Section III - Physician Information

First Name: Last Name:

Address: City: State: ZIP Code:

Phone: Fax: State License #: NPI#: DEA#: UPIN:

Office Contact Name: Phone:

Section IV - Medical Information

Primary Diagnosis: ICD-9 Code: Secondary Diagnosis: ICD-9 Code:

Medications: Strength: Directions: Quantity: # of Refills

Administration Site: Physician's Office Patient's Home Shipping To: Physician's Office Patient's Home
Home Care Agency Home Care Agency (name & address if available)

Auth Number (if required):

Prescriber's Signature (required by law):