

INSTRUCTIONS FOR ORDERING

UNIFORM NEW JERSEY PRESCRIPTION BLANKS

v080121

- **COMPLETE THE ATTACHED ORDER FORM IN FULL**
- **COMPLETE IN FULL SCRIPT INFORMATION AND ALL REQUIRED STATE AND FEDERAL CONTROL NUMBERS**
 - COMPLETE **SHIPPING INFO** *(Required)*
 - **SIGN** WHERE INDICATED *(Required)*
 - DETERMINE SCRIPT **PRICE GROUP**
- CHECK THE **QUANTITY** OF PADS DESIRED
- CHECK **PRINT OPTIONS** AS NEEDED
- **PROVIDE CONTACT INFORMATION BELOW SHOULD WE HAVE A QUESTION**
 - **EMAIL PAGES 1,2,3, AND 4 to:**
customerservice@actiongraphicsusa.com

Practice or Facility Name: _____

Your Name (please print): _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Email: _____

YOU WILL RECEIVE ACKNOWLEDGEMENT VIA EMAIL

UNIFORM NEW JERSEY PRESCRIPTION BLANKS ORDER FORM

Ordering Instructions:

1. Per state requirements, all orders and reorders for Uniform New Jersey Prescription Blanks must be submitted in writing via mail or fax.
2. Use one Order Form per prescription order. Multiple prescriber names and one address may be printed on the front of each prescription. Additional addresses may be printed on the back for an additional cost.
3. The address used for shipping **MUST MATCH** with the listing of authorized prescribers and health care facilities on file with the licensing board.
4. License numbers must be provided for each prescriber or facility.
5. The signature of each authorized prescriber or health care facility representative must be provided with each order.
6. Starting Number will start at "1" (one) for each order.

PRINT NEATLY AND CLEARLY IN BLACK PEN

Information to be Printed on Prescription Blank:

1. Practice or Facility Name (if applicable): _____ NPI # (required): _____
2. Prescriber Name: _____ Degree: _____
3. Practice or Specialty (only if to print below prescriber name(s): _____ License #: _____
4. Address to print on front: _____
 City _____ State: _____ Zip: _____
 Telephone #: _____ Fax # (if to printed): _____
5. Specify if Applicable: DEA#: _____ TPA Cert #: _____
(If DEA # is not provided, a blank line will be printed to be filled in by prescriber if applicable.) (If TPA# is not provided, a blank line will be printed to be filled in by prescriber if applicable.)
 Facility Provider #: _____ Certification #: _____

SHIPPING INFORMATION

Official Address on File with the State Board:

Street Address: _____
 City: _____ State: _____ Zip: _____

<p>IMPORTANT: If more than one prescriber is listed on the same blank, One of the prescribers is to be responsible for the shipment. That person must sign here:</p>	<p>PLEASE NOTE: By signing, you agree that you are the responsible party for this shipment of prescription blanks. Please make certain that the address given above is the same as it appears with your medical licensing board.</p>
<p>X _____</p>	

PRESCRIBER SIGNATURE: X _____
(REQUIRED EACH TIME AN ORDER IS PLACED)

NJ Scripts

NEW JERSEY PRESCRIPTION FORMS

Below are the standard layouts we will use on all New Jersey Prescription Forms.
Please see the order sheet for specific instructions.
Size" x 5½" - Face-PMS336 Green/Back-PMS229 Blue - Imprint Information Black

State of New Jersey
PRESCRIPTION BLANK

PRACTICE NAME
DOCTOR
SPECIALTY
STREET
CITY STATE ZIP
PHONE

NPI # _____ DEA # _____
LICENSE # _____
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

PRICE GROUP 1

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____
DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____
REFILL _____ TIMES _____
Use a separate form for each controlled substance prescription
THIS, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PENALIZABLE BY LAW

#1 MD, DO, DDS, DMD, DPM, DVM

State of New Jersey
PRESCRIPTION BLANK

NAME OF INSTITUTION OR FACILITY
STREET
CITY STATE ZIP
PHONE

PRINT: NAME AND TITLE OF PRESCRIBER AND, IF APPLICABLE, COLLABORATIVE PHYSICIAN

LICENSE # _____ NPI # _____
CHECK F: APRN CNM PA D
PRESCRIBER # _____
COLLABORATIVE PHYSICIAN # _____
LICENSE / CERTIFICATE / PA AUTHORIZATION # _____

PATIENT _____ D.O.B. _____
ADDRESS _____ DATE _____

Rx

PRICE GROUP 2

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____
DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____
REFILL _____ TIMES _____
IF ISSUED BY AN OPTOMETRIST, NOT VALID FOR SCHEDULE II CONTROLLED DANGEROUS SUBSTANCES, EXCEPT FOR HYDROCODONE-CONTAINING PRODUCTS
Use a separate form for each controlled substance prescription
THIS, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PENALIZABLE BY LAW

#2 Healthcare Facility

State of New Jersey
PRESCRIPTION BLANK

NAME OF PRACTICE
NAME AND ACADEMIC DEGREE
IDENTIFICATION OF PROF. PRACTICE OR SPECIALTY
STREET
CITY STATE ZIP
PHONE

NPI # _____ DEA # _____ CERT. # _____
LICENSE # _____
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

PRICE GROUP 2

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____
DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____
REFILL _____ TIMES _____
NOT VALID FOR SCHEDULE II CONTROLLED DANGEROUS SUBSTANCES, EXCEPT FOR HYDROCODONE-CONTAINING PRODUCTS
Use a separate form for each controlled substance prescription
THIS, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PENALIZABLE BY LAW

#3 Optometrist TPS Certified

State of New Jersey
PRESCRIPTION BLANK

NAME AND TITLE
STREET
CITY STATE ZIP
PHONE

NPI # _____
CERTIFICATION # _____ DEA # _____
COLLABORATING PHYSICIAN

NAME _____ NAME _____ LICENSE # _____ 00000000
(Enter Address and Phone Number only if different from above)

ADDRESS _____ STREET ADDRESS _____
CITY, STATE ZIP CODE _____ PHONE # (000) 000-0000

PATIENT _____ D.O.B. _____
ADDRESS _____ DATE _____

Rx

PRICE GROUP 2

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____
DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____
REFILL _____ TIMES _____
Use a separate form for each controlled substance prescription
THIS, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PENALIZABLE BY LAW

#4 Advanced Practice Nurse

State of New Jersey
PRESCRIPTION BLANK

NAME, ACADEMIC DEGREE, TITLE
STREET • CITY STATE ZIP
PHONE

LICENSE # _____ DEA # _____
AFFILIATED PHYSICIAN

NAME _____ PHYSICIAN NAME _____ LICENSE # _____ 0000000
TELEPHONE # _____ (000) 000-0000

PATIENT _____ D.O.B. _____
ADDRESS _____ DATE _____

Rx

PRICE GROUP 2

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____
DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____
REFILL _____ TIMES _____
Use a separate form for each controlled substance prescription
THIS, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PENALIZABLE BY LAW

#5 Certified Nurse Midwife

State of New Jersey
PRESCRIPTION BLANK

NAME OF PRACTICE
NAME AND ACADEMIC DEGREE
IDENTIFICATION OF PROF. PRACTICE OR SPECIALTY
STREET
CITY STATE ZIP
PHONE

NPI # _____
LICENSE # _____
VALID ONLY FOR PRESCRIPTION EYEWEAR

PATIENT _____ D.O.B. _____
ADDRESS _____ DATE _____

Rx	SPHERE	CYLINDER	AXIS	PRISM
OD				
OS				
ADD		P.D.		
ADD		REMARKS:		

PRICE GROUP 2

DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____
REFILL _____ TIMES _____
Use a separate form for each controlled substance prescription
THIS, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PENALIZABLE BY LAW

#6 Prescribing Eye Wear

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 _____ TITLE # _____
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

PRICE GROUP 2

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____
DO NOT REFILL _____ SIGNATURE OF PRESCRIBER _____
REFILL _____ TIMES _____
Use a separate form for each controlled substance prescription
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#8 Physician Assistant

DISCOUNT Uniform New Jersey Prescription Blanks Price List*

FOR REORDERS – Attach a sample of original Prescription Blank for Faster Processing

All imprinted information will be printed in black. 2nd part of 2 Part form is blank. (Only black copy will be printed on duplicate copies of the 2 part form is required) See "Print Face Part 2" below for additional charges. Form size is 4" x 5.5". Printed on 20# Laser Bond. 2 part forms has CB 20# white on Part 1 and CF 20# canary second part. 1 part forms are padded 100 per pad. 2 part forms are padded in 100 sets per pad (see below option for pads of 50). All orders shipped UPS Ground UNLESS indicated differently below. Each order is numbered starting at 1 (one).

PRICE GROUP 1 Doctor Format Only

PRICE GROUP 2 All Other Formats

Check Qty and Type Desired

No. Pads	1 Part (100/Pad)	2 Part (100/Pad)	No. Pads	1 Part (100/Pad)	2 Part (100/Pad)
Product Code	(PC41-NJ14)	(PC41-NJ214)	Product Code	PC4_(2,3,4,5,6,8-NJ14)	PC4_(2,3,4,5,6,8-NJ214)
5 Pads	<input type="checkbox"/> 25.50/pad	<input type="checkbox"/> 34.95/pad	5 Pads	<input type="checkbox"/> 26.15/pad	<input type="checkbox"/> 38.45/pad
10 Pads	<input type="checkbox"/> 19.15/pad	<input type="checkbox"/> 26.25/pad	10 Pads	<input type="checkbox"/> 19.60/pad	<input type="checkbox"/> 28.90/pad
20 Pads	<input type="checkbox"/> 11.35/pad	<input type="checkbox"/> 15.80/pad	20 Pads	<input type="checkbox"/> 13.10/pad	<input type="checkbox"/> 20.75/pad
40 Pads	<input type="checkbox"/> 8.35/pad	<input type="checkbox"/> 11.80/pad	40 Pads	<input type="checkbox"/> 10.15/pad	<input type="checkbox"/> 17.75/pad
60 Pads	<input type="checkbox"/> 7.60/pad	<input type="checkbox"/> 11.60/pad	60 Pads	<input type="checkbox"/> 9.50/pad	<input type="checkbox"/> 17.20/pad
80 Pads	<input type="checkbox"/> 7.15/pad	<input type="checkbox"/> 10.95/pad	80 Pads	<input type="checkbox"/> 9.20/pad	<input type="checkbox"/> 16.65/pad
120 Pads	<input type="checkbox"/> 6.80/pad	<input type="checkbox"/> 10.60/pad	120 Pads	<input type="checkbox"/> 8.90/pad	<input type="checkbox"/> 16.00/pad

Check Print Options and Additional Services Desired

Feature	Forms/Pad	5	10	20	40	60	80	120+
<input type="checkbox"/> Print face of 2nd Part per pad	100	8.30	5.80	5.20	4.90	4.90	4.90	4.80
<input type="checkbox"/> Back print 1 part form pp	100	11.80	7.80	6.00	5.40	5.20	5.00	4.90
<input type="checkbox"/> Back Print part 1 of 2 part form pp	100	12.80	8.30	6.30	5.80	5.60	5.40	5.30
<input type="checkbox"/> Pad in 50's Standard pp	0.65/pad							
<input type="checkbox"/> Proof Charge	35.00	(No proof charge for orders over 300.00)						
<input type="checkbox"/> Print Rush Service	65.00	(excludes expedited shipping cost, see below)						
<input type="checkbox"/> Expedited Shipping* select one...		<input type="checkbox"/> 3 Day Ground	<input type="checkbox"/> 2nd Day Air	<input type="checkbox"/> Next Day Before 10:30 am	<input type="checkbox"/> Next Day Air			

* ALL orders shipped UPS Ground UNLESS indicated differently above. Additional cost.

For larger quantities and/or Laser Scripts...Call: (856) 783-1825 or Email: customerservice@actiongraphicsusa.com

* • all prices are based on cash/check form of payment, subject to change without notice and do not include shipping and tax.
 • for credit card forms of payment, a 3.8% service fee will be added • ADULT SIGNATURE REQUIRED for shipping.
 • download and print current order form and pricing anytime at: www.actiongraphicsusa.com or call (856) 783-1825.

Thank You For Your Business!