PRESCRIPTION REQUEST FORM

Name (Last) (First) (M.I)

Area Code and Phone #

Address:

Date of Birth:

Date / Written

Name of Medication:

Quantity to be dispensed:

Day Supply

Instructions For Use:

Number of Refills:

Physician's Name: *Please Print*

Physician's Signature: *Stamps NOT ACCEPTED*

Address:

NPI:

DEA:

Phone:

Fax:

Mail Prescriptions To:

Orchard Pharmaceuticals
7835 Freedom Avenue N.W.
North Canton, OH 44720

Toll Free:1-866-909-5170
Fax:1-866-909-5171
Website: www.orchardrx.com

Escribe: Use NABP 3677361 to send prescriptions electronically.
Call: Monday -Friday: 8:00am - 8:00pm (EST)
Fax: Prescriptions May Be Faxed Directly From The Physician's Office 1-866-909-5171

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