

# 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 5 1/2" - 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 # \_\_\_\_\_  
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**

STATE OF NEW JERSEY

PHARMACY PRODUCT

SUBSTITUTION PERMISSIBLE \_\_\_\_\_ DO NOT SUBSTITUTE \_\_\_\_\_  
DO NOT REFILL \_\_\_\_\_ SIGNATURE OF PRESCRIBER \_\_\_\_\_  
REFILL \_\_\_\_\_ TIMES \_\_\_\_\_

Use a separate form for each controlled substance prescription  
THEY, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE 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 IF:  APN  CNM  PA  
D PRESCRIBER: 00000000  
E COLLABORATIVE PHYSICIAN: 00000000

PATIENT \_\_\_\_\_ D.O.B. \_\_\_\_\_  
ADDRESS \_\_\_\_\_ DATE \_\_\_\_\_

**Rx**

IF ISSUED BY AN OPTOMETRIST, NOT VALID FOR SCHEDULE II CONTROLLED DANGEROUS SUBSTANCES, EXCEPT FOR HYDROCODONE-CONTAINING PRODUCTS

STATE OF NEW JERSEY

PHARMACY PRODUCT

SUBSTITUTION PERMISSIBLE \_\_\_\_\_ DO NOT SUBSTITUTE \_\_\_\_\_  
DO NOT REFILL \_\_\_\_\_ SIGNATURE OF PRESCRIBER \_\_\_\_\_  
REFILL \_\_\_\_\_ TIMES \_\_\_\_\_

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#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 CERT. # \_\_\_\_\_

NPI # \_\_\_\_\_  
DEA # \_\_\_\_\_  
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**

NOT VALID FOR SCHEDULE II CONTROLLED DANGEROUS SUBSTANCES, EXCEPT FOR HYDROCODONE-CONTAINING PRODUCTS

STATE OF NEW JERSEY

PHARMACY PRODUCT

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DO NOT REFILL \_\_\_\_\_ SIGNATURE OF PRESCRIBER \_\_\_\_\_  
REFILL \_\_\_\_\_ TIMES \_\_\_\_\_

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#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**

STATE OF NEW JERSEY

PHARMACY PRODUCT

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DO NOT REFILL \_\_\_\_\_ SIGNATURE OF PRESCRIBER \_\_\_\_\_  
REFILL \_\_\_\_\_ TIMES \_\_\_\_\_

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#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 # 00000000  
TELEPHONE # (000) 000-0000

PATIENT \_\_\_\_\_ D.O.B. \_\_\_\_\_  
ADDRESS \_\_\_\_\_ DATE \_\_\_\_\_

**Rx**

STATE OF NEW JERSEY

PHARMACY PRODUCT

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DO NOT REFILL \_\_\_\_\_ SIGNATURE OF PRESCRIBER \_\_\_\_\_  
REFILL \_\_\_\_\_ TIMES \_\_\_\_\_

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#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 # \_\_\_\_\_  
DEA # \_\_\_\_\_  
**VALID ONLY FOR PRESCRIPTION EYEWEAR**

PATIENT \_\_\_\_\_ D.O.B. \_\_\_\_\_  
ADDRESS \_\_\_\_\_ DATE \_\_\_\_\_

**Rx**

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

DO NOT REFILL \_\_\_\_\_ SIGNATURE OF PRESCRIBER \_\_\_\_\_  
REFILL \_\_\_\_\_ TIMES \_\_\_\_\_

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#6 Prescribing Eye Wear

State of New Jersey  
**PRESCRIPTION BLANK**

NAME AND TITLE OF PHYSICIAN ASSISTANT  
NAME OF PROFESSIONAL PRACTICE  
TELEPHONE # \_\_\_\_\_

NPI # \_\_\_\_\_  
DEA # \_\_\_\_\_  
LICENSE # \_\_\_\_\_

NAME, DEGREE (SUPERVISING PHYSICIAN)  
CITY, STATE ZIP PHONE

DELEGATED PHYSICIAN SUPERVISOR  
LICENSE # \_\_\_\_\_ TEL # \_\_\_\_\_

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PATIENT \_\_\_\_\_ D.O.B. \_\_\_\_\_  
ADDRESS \_\_\_\_\_ DATE \_\_\_\_\_

**Rx**

PD  
 BP

STATE OF NEW JERSEY

PHARMACY PRODUCT

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REFILL \_\_\_\_\_ TIMES \_\_\_\_\_

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#8 Physician Assistant