Prescription Request for Vaccine

DATE:

TO:

FROM:

Prescriber's Name

Street Address | City | State | Zip Code

Fax Number

We are pleased to be an active partner in your patient's health care. We would like to request a prescription* for the following vaccine(s) for your patient:

Patient's Name *(for pharmacist to complete)* | Patient's Birth Date

Street Address | City | State | Zip Code

Vaccine Name | Vaccine Name

PRESCRIBER - By signing below you agree to the administration of this vaccine(s) for this patient in this pharmacy. Please return signed form to the pharmacy listed below via fax

Print Name of Prescriber | State License Number

Signature of Prescriber | DEA Number

Pharmacy Name | Pharmacy Fax

Pharmacy Address | Pharmacy Phone

If you have any questions about this request, please contact the pharmacy.

***Prescriber** - This form is not designed to meet the prescription requirements in every state as these requirements vary. Please check the requirements in your state prior to utilizing this form as a prescription.

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US-NON-03162 03/20