

# INSTRUCTIONS FOR ORDERING

## UNIFORM NEW JERSEY PRESCRIPTION BLANKS

v0523

- COMPLETE Pages 1, 2, and 3 In Full
- COMPLETE Script Information and all Required State and Federal Control Numbers
  - COMPLETE Shipping Information (*Required*)
    - SIGN Where Indicated (*Required*)
    - DETERMINE Script Price Group
  - CHECK Quantity of Pads and/or Laser Sheets Desired
  - CHECK Print Options as Needed.
- PROVIDE Contact Information Below should we have Question
  - EMAIL PAGES 1, 2, and 3 to:  
[scripts@newjerseyprescriptionblanks.com](mailto:scripts@newjerseyprescriptionblanks.com)

Practice or Facility Name: \_\_\_\_\_

Your Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**YOU WILL RECEIVE ACKNOWLEDGEMENT VIA EMAIL**

**ACTION GRAPHICS • Tel: (856) 783-1825 • [www.actiongraphicsusa.com](http://www.actiongraphicsusa.com)**

[scripts@newjerseyprescriptionblanks.com](mailto:scripts@newjerseyprescriptionblanks.com)

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# 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: \_\_\_\_\_

**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:

**X** \_\_\_\_\_

**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.

**PRESCRIBER SIGNATURE: X** \_\_\_\_\_

*(REQUIRED EACH TIME AN ORDER IS PLACED)*

# 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) Product Code (PC41-NJ14)	2 Part (100/Pad) Product Code (PC41-NJ214)	No. Pads	1 Part (100/Pad) Product Code PC4_(2,3,4,5,6,8-NJ14)	2 Part (100/Pad) Product Code PC4_(2,3,4,5,6,8-NJ214)
8 Pads	<input type="checkbox"/> 27.00/pad	<input type="checkbox"/> 37.60/pad	8 Pads	<input type="checkbox"/> 27.70/pad	<input type="checkbox"/> 41.40/pad
10 Pads	<input type="checkbox"/> 22.30/pad	<input type="checkbox"/> 29.75/pad	10 Pads	<input type="checkbox"/> 22.10/pad	<input type="checkbox"/> 33.50/pad
20 Pads	<input type="checkbox"/> 12.10/pad	<input type="checkbox"/> 17.10/pad	20 Pads	<input type="checkbox"/> 13.90/pad	<input type="checkbox"/> 22.30/pad
40 Pads	<input type="checkbox"/> 8.90/pad	<input type="checkbox"/> 12.80/pad	40 Pads	<input type="checkbox"/> 10.80/pad	<input type="checkbox"/> 19.10/pad
60 Pads	<input type="checkbox"/> 8.10/pad	<input type="checkbox"/> 12.60/pad	60 Pads	<input type="checkbox"/> 10.10/pad	<input type="checkbox"/> 18.60/pad
80 Pads	<input type="checkbox"/> 7.60/pad	<input type="checkbox"/> 11.90/pad	80 Pads	<input type="checkbox"/> 9.80/pad	<input type="checkbox"/> 17.90/pad
120 Pads	<input type="checkbox"/> 7.30/pad	<input type="checkbox"/> 11.50/pad	120 Pads	<input type="checkbox"/> 9.50/pad	<input type="checkbox"/> 17.30/pad

#### Check Print Options and Additional Services Desired

Feature	Forms/Pad	8	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	0.90/pad							
<input type="checkbox"/> Proof Charge	35.00	(No proof charge for orders over 300.00)						
<input type="checkbox"/> <b>Print</b> Rush Service	65.00	(excludes expedited shipping cost, see below)						
<input type="checkbox"/> <b>Expedited</b> 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: [scripts@newjerseyprescriptionblanks.com](mailto:scripts@newjerseyprescriptionblanks.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 • NJ State REQUIRES ADULT SIGNATURE at time of delivery.  
 • download and print current order form and pricing anytime at: [www.newjerseyprescriptionblanks.com](http://www.newjerseyprescriptionblanks.com) or call (856) 783-1825.

*Thank You For Your Business!*

# New Jersey Prescription Products by Group for Ordering

## 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 # \_\_\_\_\_  
LICENSE # \_\_\_\_\_ 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**

**PRICE GROUP 1**

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

Use a separate form for each controlled substance prescription  
THIS UNAUTHORIZED PRESCRIPTION AND/OR USE OF THIS FORM INCLUDING ACTIVITIES OR PENALTIES, ARE CRIMES PERMISSIBLE 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:  APR  CNM  PA  D PRESCRIBER: 000000000  
COLLABORATIVE PHYSICIAN: 000000000

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

**PRICE GROUP 2**

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

Use a separate form for each controlled substance prescription  
THIS UNAUTHORIZED PRESCRIPTION AND/OR USE OF THIS FORM INCLUDING ACTIVITIES OR PENALTIES, ARE CRIMES PERMISSIBLE 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 CERT. # \_\_\_\_\_

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

**PRICE GROUP 2**

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

Use a separate form for each controlled substance prescription  
THIS UNAUTHORIZED PRESCRIPTION AND/OR USE OF THIS FORM INCLUDING ACTIVITIES OR PENALTIES, ARE CRIMES PERMISSIBLE 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**

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

Use a separate form for each controlled substance prescription  
THIS UNAUTHORIZED PRESCRIPTION AND/OR USE OF THIS FORM INCLUDING ACTIVITIES OR PENALTIES, ARE CRIMES PERMISSIBLE 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 # \_\_\_\_\_ 000000  
TELEPHONE # \_\_\_\_\_ (000) 000-0000

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

**Rx**

**PRICE GROUP 2**

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

Use a separate form for each controlled substance prescription  
THIS UNAUTHORIZED PRESCRIPTION AND/OR USE OF THIS FORM INCLUDING ACTIVITIES OR PENALTIES, ARE CRIMES PERMISSIBLE 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 \_\_\_\_\_

<b>Rx</b>	SPHERE	CYLINDER	AXIS	PRISM
	OD	<b>PRICE GROUP 2</b>		
	OS			
	ADD	P.D. _____		
	ADD	REMARKS _____		

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

Use a separate form for each controlled substance prescription  
THIS UNAUTHORIZED PRESCRIPTION AND/OR USE OF THIS FORM INCLUDING ACTIVITIES OR PENALTIES, ARE CRIMES PERMISSIBLE BY LAW

#6 Prescribing Eye Wear

State of New Jersey  
**PRESCRIPTION BLANK**

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

NPI # \_\_\_\_\_  
LICENSE # \_\_\_\_\_ DEA # \_\_\_\_\_  
NAME, DEGREE (SUPERVISING PHYSICIAN)  
CITY, STATE ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

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

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**

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

Use a separate form for each controlled substance prescription  
THIS UNAUTHORIZED PRESCRIPTION AND/OR USE OF THIS FORM INCLUDING ACTIVITIES OR PENALTIES, ARE CRIMES PERMISSIBLE BY LAW

#8 Physician Assistant