



## Temporary Prescription Form

Client Name: **Warren County**

### 1. Instructions for the **EMPLOYER**:

- Provide this form to your injured worker to have any prescription filled for a temporary **10 day supply**, and please fill out the information below:

Claimant Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Claimant DOB: \_\_\_\_\_ Claimant's Home Phone #: \_\_\_\_\_  
Claimant Employer: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
Claimant Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer Representative: \_\_\_\_\_ Date: \_\_\_\_\_

### 2. Instructions for the **INJURED WORKER**:

- **You, the injured worker will need to bring this form and provide it to the pharmacy along with your prescriptions related to the treatment of your work related injury/illness**

### 3. Instructions for the **PHARMACY**:

- Please submit workers' compensation claims to **AWPRX**
- **BIN**                   **610237**
- **PCN**                   **AWPRX**
- **Group ID**           **AWPRx63**
- **ID number**         **Use Social Security from the top of the form**
- Prescription(s) will fill for a **10 Day Supply**. If there is a remaining balance on the script after the **10 Day Supply** is filled, AWPRx will call back if and when the balance has been approved. If you need assistance, please call **AWPRx** at **888-700-0922**.

AWPRx office hours are Monday through Friday, 8:00AM EST to 8:00PM EST. We also have representative's on-call 24 hours/7 days a week.

**FOR ALL REJECTIONS OR QUESTIONS CALL: (888)-700-0922**