CaryRx

Please sign and fax complete form to CaryRx at:
FAX: 1-202-930-4243
PHONE: 1-202-930-4242

mahana™

Any questions?
Call 844-624-0544
www.mahana.com

Patient Information

First Name: _____ MI: _____ Last Name: _____

DOB (mm/dd/yyyy): _____/ _____/ _____ ○ Male ○ Female

Street Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Alternative Phone: _____

Healthcare Provider Information

HCP Name: _____ ○ MD ○ DO ○ PA ○ NP

State License#: _____ Physician NPI#: _____

Office Name: _____ Phone: _____ Fax: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Office Contact Name: _____ Office Contact Phone: _____

Office Contact Email: _____

Prescription Information

Mahana IBS

Directions for use: ○ Use as directed ○ Other: _____

Quantity: 1

Refill (please circle): 0 1 2 3

Provider Consent

I authorize the forwarding of this prescription and information to CaryRx.

SIGN HERE

Prescriber Signature (No Stamps) Date:

x _____ _____/_____/_____