

# 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 5-1/2" X 4" - Face-Reflex Blue/Back-Green - Imprint Information Black

State of New Jersey  
**PRESCRIPTION BLANK**

FACILITY NAME  
DOCTOR  
SPECIALTY  
STREET  
CITY STATE ZIP

DEA # \_\_\_\_\_ LIC. # 0000000  
BATCH # PRT0000000000 NPI # \_\_\_\_\_ SERIAL # 000001

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**

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

Use 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, DS, DMD, DPM, DVM

State of New Jersey  
**PRESCRIPTION BLANK**

NAME OF INSTITUTION OR FACILITY

STREET ADDRESS

TELEPHONE: \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_ FACILITY PROVIDER #: \_\_\_\_\_  
BATCH # PRT0000000000 SERIAL #: 000001

PRINT CLEARLY: NAME & TITLE OF PRESCRIBER & IF APPLICABLE, SUPERVISOR / COLLABORATIVE PHYSICIAN

CHECK #  APR  CHM  PA  PRT  
LIC. # \_\_\_\_\_ DEPT. # \_\_\_\_\_ DEPT. # \_\_\_\_\_  
LICENSURE / CERT. # \_\_\_\_\_ DEPT. # \_\_\_\_\_ DEPT. # \_\_\_\_\_  
Rx AUTHORIZATION # \_\_\_\_\_ NPI # \_\_\_\_\_

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

**Rx**

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

Use 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

#2 Health Care Facility

State of New Jersey  
**PRESCRIPTION BLANK**

NAME OF PRACTICE  
NAME AND ACADEMIC DEGREE  
IDENTIFICATION OF PROF. PRACTICE OR SPECIALTY  
STREET ADDRESS  
CITY, STATE, ZIP CODE

LIC. # 0000000 CITY, STATE, ZIP CODE DEPT. # \_\_\_\_\_  
CERT. # \_\_\_\_\_ TELEPHONE NPI # \_\_\_\_\_  
BATCH # PRT0000000000 SERIAL # 000001

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.

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

Use separate form for each controlled substance prescription  
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#3 Optometrist TPA Certified

State of New Jersey  
**PRESCRIPTION BLANK**

NAME AND TITLE  
STREET ADDRESS  
CITY, STATE ZIP  
TELEPHONE

DEA # \_\_\_\_\_ CERTIFICATION # \_\_\_\_\_  
BATCH # PRT0000000000 NPI # \_\_\_\_\_ SERIAL # 000001

COLLABORATING PHYSICIAN

NAME: NAME \_\_\_\_\_ LICENSE # \_\_\_\_\_ 00000000  
(Enter Address & Phone & only if different from above)

ADDRESS: STREET ADDRESS \_\_\_\_\_  
CITY, STATE AND ZIP CODE \_\_\_\_\_ PHONE # \_\_\_\_\_ (000) 000-0000

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

**Rx**

DO NOT REFILL \_\_\_\_\_ SIGNATURE OF ADVANCED PRACTICE NURSE & TITLE \_\_\_\_\_  
REFILL \_\_\_\_\_ TIMES

Use separate form for each controlled substance prescription  
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#4 Nurse Practitioner/  
Clinical Nurse Specialist

State of New Jersey  
**PRESCRIPTION BLANK**

NAME, ACADEMIC DEGREE & TITLE \_\_\_\_\_ LICENSE (Rx AUTH) # \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_ DEPT. # \_\_\_\_\_  
CITY, STATE AND ZIP CODE \_\_\_\_\_ BATCH # PRT0000000000  
(000) 000-0000 NPI # \_\_\_\_\_ SERIAL # 000001

COLLABORATIVE PHYSICIAN

NAME PHYSICIAN NAME \_\_\_\_\_ LICENSE # \_\_\_\_\_ 0000000000  
TELEPHONE # \_\_\_\_\_ (000) 000-0000

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

**Rx**

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

Use separate form for each controlled substance prescription  
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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 ADDRESS  
CITY, STATE AND ZIP CODE

LIC # 0000000 (000) 000-0000 BATCH # PRT0000000000  
NPI # \_\_\_\_\_ SERIAL # 000001

**VALID ONLY FOR PRESCRIPTION EYE WEAR**

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

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

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

Use 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

#6 Prescribing Eye Wear

State of New Jersey  
**PRESCRIPTION BLANK**

PRACTICE NAME  
NAME AND ACADEMIC DEGREE  
SPECIALTY  
STREET ADDRESS  
CITY, STATE, ZIP

LIC. # 0000000 NPI # \_\_\_\_\_  
CERT. # \_\_\_\_\_ DEPT. # \_\_\_\_\_  
BATCH # PRT0000000000 TELEPHONE SERIAL # 000001

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** - VALID FOR PRESCRIPTION EYEWEAR -  
- VALID FOR TOPICAL PHARMACEUTICAL AGENTS AND ORAL MEDICATIONS -  
- NOT VALID FOR SCHEDULE II CONTROLLED DANGEROUS SUBSTANCES -

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

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

Use separate form for each controlled substance prescription  
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#7 Combo Eye Wear/TPA Certified

State of New Jersey  
**PRESCRIPTION BLANK**

NAME AND TITLE OF PHYSICIAN ASSISTANT

NAME OF PROFESSIONAL PRACTICE  
STREET ADDRESS  
CITY, STATE ZIP

TELEPHONE # \_\_\_\_\_ DEPT. # \_\_\_\_\_  
BATCH # PRT0000000000 NPI # \_\_\_\_\_ SERIAL # 000001

NAME, DEGREE (SUPERVISING PHYSICIAN)  
STREET ADDRESS \_\_\_\_\_ LICENSE # \_\_\_\_\_  
CITY, STATE ZIP \_\_\_\_\_ TEL. # \_\_\_\_\_

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

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**

PRT  
 SPD

DO NOT REFILL \_\_\_\_\_ SIGNATURE OF PHYSICIAN ASSISTANT \_\_\_\_\_  
REFILL \_\_\_\_\_ TIMES

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#8 Physician Assistant