

CA Controlled Substance RX Pad Pricing

**1 part pads
100 scripts per pad**

# of pads	Price per pad
4	\$14.95
8	\$ 7.25
12	\$ 6.25
16	\$ 4.95
20	\$ 4.25
24	\$ 3.95
40	\$ 3.45
60	\$ 3.25
100	\$ 3.15
240	\$ 2.95

**2 part pads
50 scripts per pad**

# of pads	Price per pad
4	\$22.95
8	\$12.95
12	\$ 9.35
16	\$ 7.95
20	\$ 7.25
24	\$ 6.25
40	\$ 5.45
60	\$ 5.25
100	\$ 4.75
240	\$ 3.95

**2 part pads
100 scripts per pad**

# of pads	Price per pad
4	\$32.10
8	\$16.25
12	\$11.75
16	\$11.25
20	\$10.95
24	\$ 9.95
40	\$ 9.45
60	\$ 8.75
100	\$ 7.75
240	\$ 6.95

No set up fees ▲ No charge for proofs*
***\$30.00 Cancellation Fee if order is cancelled after proof is produced**

Approved distributor for California

Toll Free - 1 800 852-5565 Fax - 801-487-0118
www.advantageforms.com

THIS DOCUMENT CONTAINS A VOID PANTOGRAPH • THERMOCHROMIC INK • CHEMICAL VOID ALTERATION FEATURES • MICRO-PRINT RULES THAT READ "CALIFORNIA SECURITY PRESCRIPTION" ON THE FACE OF THE FORM • AN OPAQUE WATERMARK ON THE BACK THAT READS "CALIFORNIA SECURITY PRESCRIPTION" • SECURITY REVERSE RX # 1011 • SEQUENTIAL #

Doctor's Name, M.D. LOT # C00000
 Practice
 123 Main Street, Suite 100
 Anytown, CA 91234
 Phone (123) 456-7890 • Fax (123) 456-7890
 DEA# AB1234567 • LIC# A12345 • NPI# 1234567890

Name _____ DOB _____
 Address _____ Date _____

Style #1
NEW REQUIRED FORMAT
Check boxes on refills.

1-24
 25-49
 50-74
 75-100
 101-150
 151 and over
 Units _____

REFILLS: NR 1 2 3 4 5
 Void after _____ Signature _____
 Do Not Substitute - Dispense As Written

PRESCRIPTION IS VOID IF THE NUMBER OF DRUGS PRESCRIBED IS NOT NOTED: _____ CARXADV4 (1017) SP24

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Doctor's Name, M.D. LOT # C00000
 123 Main Street, Suite 100
 Anytown, CA 91234
 Phone (123) 456-7890 • Fax (123) 456-7890
 DEA# AB1234567 • LIC# A12345 • NPI# 1234567890

Patient Name _____ Phone No. _____
 Address _____ Age _____ Gender _____

1) **Style #2**
NEW REQUIRED FORMAT
Check boxes on refills.

Quantity: 1-24 25-49 50-74
 75-100 101-150 151 and over
 Units _____ Do Not Substitute
 Refills: NR 1 2 3 4 PRN

2) Quantity: 1-24 25-49 50-74
 75-100 101-150 151 and over
 Units _____ Do Not Substitute
 Refills: NR 1 2 3 4 PRN

3) Quantity: 1-24 25-49 50-74
 75-100 101-150 151 and over
 Units _____ Do Not Substitute
 Refills: NR 1 2 3 4 PRN

No Refills allowed for Schedule II
 LABEL IN SPANISH

X _____ DATE _____
 Prescription is VOID if the number of drugs prescribed is not noted: _____ CARXADV3 (1017) SP24

Style: #1 #2 1 Part Pads 2 Part Pads Pad in: 50's 100's **ORDER FORM**

Wrap Around Covers - Add \$2.00 per pad yes no

Quantity: _____ (# of Pads) Contact for questions: _____

Send Proof to:

Fax #: _____ OR E-mail: _____

Imprint Info: (fill out or fax current script)

Practice Name: _____

Physician Name: _____

Specialty: _____

Address: _____

City _____ State _____ Zip _____

Phone: _____ Fax: _____

DEA #: _____ **(Required)**

License #: _____ **(Required)** NPI #: (optional) _____