



Workers' Compensation First Fill Program

1. Instructions for the **EMPLOYER**:

- Provide this form to your injured worker to have any prescription filled for a temporary **7 Days**, and please fill out the information below:

Injured Worker Name:

SS#:

Injured Worker DOB:

Injured Worker Phone:

Injured Worker Employer:

Date of Injury:

Injured Worker Address:

City:

State:

Zip:

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** using the following information:

BIN	PCN	Group Id	Member Id
610237	AWPRX	AWPMRM01	Injured Worker SS#

- Prescription(s) will fill for a **7 Days**. If there is a remaining balance on the script after the **7 Days** is filled, AWPRx will call back if and when the balance has been approved. If you need assistance, please call **AWPRx** at **(888) 356-3332**.

Representative's on-call 24 hours/7 days a week.

FOR ALL REJECTIONS OR QUESTIONS CALL: (888) 356-3332

