Temporary Prescription Form

Client Name: Minnesota Counties Intergovernmental Trust

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	MCIT1	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

The Right Med. At The Right Time. At The Right Price.