

Your CVS Caremark Mail Service Pharmacy

Your CVS Caremark Prescription Benefit

How would you like to have your long-term medicine conveniently delivered to your home or office? Not only will it save you time and trips to a participating retail pharmacy, you may also save money! With mail service, you can receive up to a 90-day supply of your medicine for a copay* that may be significantly less than you would pay at a participating retail pharmacy.

With the CVS Caremark Mail Service Pharmacy you can:

- Receive an extended supply of medicine
- Enjoy the convenience of having your medicine delivered to a location of your choice – home, office, vacation spot
- Speak to a registered pharmacist 24 hours a day, seven days a week
- Order prescriptions and get health information online at www.caremark.com

Getting Started

If you need your prescription filled right away, ask your doctor to write two prescriptions for your long-term medicines:

- The first for a short-term supply (e.g., 30 days) to be filled right away at a participating retail pharmacy

*Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

- The second for the maximum days supply allowed (up to a 90-day supply) with as many as three refills (if appropriate) to be mailed to CVS Caremark Mail Service Pharmacy

If you're not in a hurry, just mail your prescription for a 90-day supply (with any appropriate refills) to CVS Caremark.

Filling Out the Mail Service Order Form

Follow these five steps to fill out the mail service order form:

STEP 1 – Benefit ID Number

1. Fill in your ID number from your benefit ID card. (On your next order, your ID number will be pre-printed on your order form.)

CVS CAREMARK
PO BOX 94467
PALATINE IL 60094-4467

Enter ID# if not shown or different from above

Prescription Plan Sponsor or Company Name

DIRECTIONS: Print in **BLUE** or **BLACK** ink, using **CAPITAL** letters. Fill in ovals completely on both sides of form.

To order new prescriptions: Mail your prescription(s) with this form. # of new prescriptions: _____

To order refills: Order by Web, phone, or write in rx number(s) below. # of refills: _____

FOR FASTEST SERVICE, order refills at www.caremark.com or call the number on your benefit identification card.

SHIPPING ADDRESS IF NOT SHOWN OR DIFFERENT FROM ABOVE:

Last Name _____ First Name _____

Street Address _____ Apt./Suite# _____

City _____ State _____ ZIP Code _____

Daytime Phone #: _____ Evening Phone #: _____

STEP 2 – Address

2. Fill in your complete address. Be sure to fill in the oval if the address listed is a one-time only address.

STEP 3 – Prescription Information

3. Provide the requested information for the first person for whom a prescription(s) is being submitted.
 - Indicate if you would like your order to include Easy-Open Caps. All orders are normally shipped with safety caps or dual-purpose caps (which can be converted from child safe to easy open).
 - Be sure to completely fill out your Doctor's First Name, Last Name and Telephone Number.
 - Fill in the ovals under "Allergies" if you are allergic to any drugs or foods. If you do not see the allergy listed, fill in the "Other" oval and write in the allergy.
 - Fill in the ovals if you have any health "Conditions." If you do not see your health condition listed, fill in the "Other" oval and write in the health condition.
- 3a. Provide the requested information for the second person for whom a prescription(s) is being submitted (if applicable). If this is the case, provide the same information as STEP 3.

FILL IN FOR UP TO TWO PEOPLE WHO WILL RECEIVE PRESCRIPTIONS WITH THIS ORDER

1st PERSON ORDERING A PRESCRIPTION Easy open caps Print in 5

LAST NAME _____ FIRST NAME _____

NICKNAME _____ Gender: M F Date of Birth: MM-DD-YYYY _____

Your E-mail: _____ Date new prescription written: _____

Doctor's Last Name _____ Doctor's First Name _____ Doctor's Phone # _____

ALLERGY/HEALTH INFORMATION: COMPLETE ONLY IF CHANGED OR NOT PREVIOUS

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Penicillin

Sulfas Other: _____

Conditions: Arthritis Asthma Diabetes Acid Reflux Glaucoma

High Blood Pressure High Cholesterol Migraine Osteoporosis Prostate Issues

Other: _____

2nd PERSON ORDERING A PRESCRIPTION Easy open caps Print in 5

LAST NAME _____ FIRST NAME _____

NICKNAME _____ Gender: M F Date of Birth: MM-DD-YYYY _____

Your E-mail: _____ Date new prescription written: _____

Doctor's Last Name _____ Doctor's First Name _____ Doctor's Phone # _____

ALLERGY/HEALTH INFORMATION: COMPLETE ONLY IF CHANGED OR NOT PREVIOUS

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Penicillin

Sulfas Other: _____

