

# 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](http://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](http://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

Sulfa  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

Sulfa  Other: \_\_\_\_\_



