# PrimeMail™ Pharmacy Order Form — MEMBER INFORMATION

**INSTRUCTIONS:** Please PRINT in CAPITAL letters using **black ink** only. Fill in the applicable ovals completely (●).

Questions? Call PrimeMail Pharmacy at 877.35.PRIME (877.357.7463) or visit our web site at **www.myrxhealth.com**.
¿Preguntas? Llame la farmacia de PrimeMail en 877.357.7463 o el registro sobre nuestro sitio del web en **www.myrxhealth.com**.

**Member and Dependent History Section information is required only on the first order unless there is a change in health status.** Indicate all known allergies, conditions or other current medications for you, your spouse, or your dependents by filling in the corresponding oval that matches the description. Please detail * as necessary. Contact your physician if you are unsure about any of this information.

**If a family member does not want his or her medicine sent in the same package as that of other family members, he or she should complete a separate form.**

PRIME Therapeutics®

## MEMBER AND DEPENDENT HISTORY SECTION

Member ID Number (on face of member ID card)

Group Number (on face of member ID card)

Member Last Name

Sex: M F

Member First Name MI Birth Date (MM/DD/YYYY)

PCN (on face of member ID card) Member Phone Number

Delivery Address

City State Zip Code

Email Address

Dependent Last Name Sex: M F

Dependent First Name MI Birth Date (MM/DD/YYYY)

Email Address

Dependent Last Name Sex: M F

Dependent First Name MI Birth Date (MM/DD/YYYY)

Email Address

Dependent Last Name Sex: M F

Dependent First Name MI Birth Date (MM/DD/YYYY)

Email Address

| ALLERGIES | | | | | | | CONDITIONS | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| None Known | Aspirin | Codeine | Penicillin | Sulfa | Tetracycline | Other Allergy* | None Known | Diabetes | Epilepsy | Glaucoma | Heart Condition | Hypertension | Ulcer | Other Condition* |
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

*Please detail "other allergy" or "other condition" for each member referenced above, including related medications.

# PrimeMail™ Pharmacy Order Form — ORDER INFORMATION

## PRESCRIPTION SECTION — Please PRINT in CAPITAL letters using **black ink** only.

For **NEW** prescriptions you may use either:

- **FAX** — Your physician must fax both pages of this completed form, along with your prescription(s), to **877.PRIME.60** (877.774.6360); orders not faxed from a licensed physician's office will not be processed (fax orders must use credit card payment)
- **MAIL** — Mail the original physician-signed prescription (ask for the maximum-days supply) with this form to: **PrimeMail Pharmacy, P.O. Box 650041, Dallas, TX 75265-0041**

For **REFILL** prescriptions you may use either:

- **PHONE** — Call our automated refill line, 7 days a week 24 hours a day, at **877.35.PRIME** (877.357.7463) and follow the system prompts
- **WEB** — Log on to **www.myrxhealth.com** and follow the instructions
- **MAIL** — Mail this form with the refill information completed to: **PrimeMail Pharmacy P.O. Box 650041, Dallas, TX 75265-0041**

Member ID Number (on face of member ID card)

Member Birth Date (MM/DD/YYYY)

Member Last Name

Member First Name

MI

| Prescription | Member | Spouse | Dependent | Birth Date (M M D D Y Y Y Y) | Physician Name/Phone Number (for new prescriptions only) | Prescription Numbers (for refills only) |
|---|---|---|---|---|---|---|
| 1 | 0 | 0 | 0 | | | |
| 2 | 0 | 0 | 0 | | | |
| 3 | 0 | 0 | 0 | | | |
| 4 | 0 | 0 | 0 | | | |

**PrimeMail Pharmacy staff may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product. PrimeMail Pharmacy will dispense FDA-approved generic equivalents when available and appropriate.**

## DELIVERY SECTION — Delivery date does not include prescription processing time. Please choose your shipping method.

0 **Regular** – no charge 0 **Second Business Day** — $9* 0 **Next Business Day** — $15* ***Additional costs charged to you**

Delivery Address (If you've chosen Second Business Day or Next Business Day shipping, no P.O. boxes will be accepted)

City State Zip Code Phone Number

Above delivery address is: 0 For this order only 0 For this and all future orders

**All medications in this order will be sent in the same package to the address provided. If a family member's medication should not be shipped in the same package, his or her prescription order should be mailed separately.**

## PAYMENT SECTION — Payment is due with each order and may be made by credit card, check or money order.

Credit card is the only payment option for faxed orders and offers greater member convenience. There is a $20 returned check charge. **Do not send cash.** Orders received without payment will delay processing. Any outstanding balances will be the responsibility of the primary insured. If you have questions about your payment amount, call PrimeMail Pharmacy Member Services at **877.35.PRIME** (877.357.7463).

0 **Payment by check or money order** (Make payable to Prime Therapeutics LLC and write your member ID number on the memo line.)

0 **Payment by credit card** (Provide information below) 0 MasterCard 0 Visa 0 American Express 0 Discover

Credit Card Number

Expiration Date (MM/YYYY)

Your credit card will be charged for drug costs, expedited shipping (if requested) and any outstanding balances due.

**Yes** **No** Please retain this credit card information for my future home delivery purchases.

0 0

Credit Card Holder's Signature

**By returning this form to PrimeMail, you consent to the use and release of your health information and that of your covered dependents (if you are their guardian or authorized representative) to your health plans and health care providers/agents for health benefits management. Prime Therapeutics' use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).**

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