



CVS Caremark Mail Service

Your CVS Caremark Mail Service Pharmacy

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 or 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.



**Note: Copay or coinsurance means the amount you are responsible to pay, based on your plan. This 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.*

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.
- 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

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

Step 2—Address

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

Mail this form to:
CVS CAREMARK
PO BOX 94467
PALATINE, IL 60094-4467

Enter ID # below if not shown or if different from the one on your prescription benefit ID card.

Prescription Plan Sponsor or Company Name

Please use **blue or black ink, capital letters**, and fill in **both sides** of this form.

New Prescriptions - Mail your new prescriptions with this form. Number of **New** prescriptions:

Refills - Order by Web, phone, or write in Rx number(s) below. Number of **Refill** prescriptions:

FOR FASTEST SERVICE, order refills at www.caremark.com or call the number on your prescription benefit ID Card.

A Shipping Address. To ship to an address different from the one printed above, please make changes here.

Last Name First Name MI Suffix (JR, SR)

Street Name Apt./Suite #

City State ZIP Code

Use this address for this order only.

Step 3—Prescription information

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 phone 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 under *Conditions* 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.

G Tell us about the people getting prescriptions. If there are more than two people, please complete another form.

1st person with a refill or new prescription. This person needs: ☐ Easy open caps ☐ Spanish forms and labels

LAST NAME FIRST NAME Suffix (JR, SR)

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 #

Tell us about **new** allergies or health information. Only tell us about **new** information.

Allergies: ☐ None ☐ Aspirin ☐ Cephalosporin ☐ Codeine ☐ Erythromycin ☐ Peanuts ☐ Penicillin ☐ Sulfonamides ☐ Other:

Health Information: ☐ Arthritis ☐ Asthma ☐ Diabetes ☐ Acid Reflux ☐ Glaucoma ☐ Heart Problem ☐ High Blood Pressure ☐ High Cholesterol ☐ Migraine ☐ Osteoporosis ☐ Prostate Issues ☐ Thyroid ☐ Other:

2nd person with a refill or new prescription. This person needs: ☐ Easy open caps ☐ Spanish forms and labels

3a. Provide the requested information for the second person for whom a prescription is being submitted (if applicable). If this is the case, provide the same information as Step 3.

2nd person with a refill or new prescription. This person needs: ☐ Easy open caps ☐ Spanish forms and labels

LAST NAME FIRST NAME Suffix (JR, SR)

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 #

Tell us about **new** allergies or health information. Only tell us about **new** information.

Allergies: ☐ None ☐ Aspirin ☐ Cephalosporin ☐ Codeine ☐ Erythromycin ☐ Peanuts ☐ Penicillin ☐ Sulfonamides ☐ Other:

Health Information: ☐ Arthritis ☐ Asthma ☐ Diabetes ☐ Acid Reflux ☐ Glaucoma ☐ Heart Problem ☐ High Blood Pressure ☐ High Cholesterol ☐ Migraine ☐ Osteoporosis ☐ Prostate Issues ☐ Thyroid ☐ Other:

Step 4—Method of payment

Fill in the appropriate oval for your method of payment. You can pay using an electronic check, Bill Me Later® or credit/debit card (VISA®, MasterCard®, Discover® or American Express®). If you are paying by check or money order, please write your benefit ID number on the check. **Please do not send cash.**

Note: electronic check and Bill Me Later® require pre-registration by logging on to www.caremark.com or by calling Customer Care.

E How would you like to pay for this order? Fill in the oval to choose a payment.

☐ **Electronic Check.** Pay from your bank account. First time users register online or call Customer Care.

☐ **Bill Me Later®.** Works like a credit card. First time users register online or call Customer Care.

☐ **Credit or Debit Card.** (VISA®, MasterCard®, Discover®, or American Express®)

☐ Fill in this oval to use your card on file.

☐ Fill in this oval to use a new card or to update your card information.

CARD NUMBER 3rd expiration date: MM-YY

☐ **Check or Money Order.** Amount: \$

• Make check or money order out to CVS

• Write your prescription benefit ID number on the back of the check or money order.

• If your check is returned, we will charge you up to \$40.

Payment for Balance Due and Future Orders: If you chose Electronic Check, Bill Me Later®, or a Credit or Debit Card, we will also use it to pay for any balance that you owe and for future orders.

☐ Fill in this oval if you **DO NOT** want to use this payment method for future orders.

Credit Card Holder Signature/Date

Regular delivery is free and will take 7 to 10 days from the day you send this form.

If you want faster delivery, choose:

☐ **2nd Business Day (\$17)** Business days only

☐ **Next Business Day (\$23)** Monday-Friday

• Faster delivery charges may change.

• Faster delivery is for shipping time, not processing time.

• Faster delivery can only be sent to a street address, not a PO box.

Step 5—Enclose your prescription

Make sure you enclose the original prescription(s) you receive from your doctor (not photocopies).

Mail it in

Now, simply mail your order form along with your prescription(s) and payment in the envelope provided, or use your own envelope and mail the form and payment to the CVS Caremark Mail Service Pharmacy address printed on the form. Please be sure to fold the mail service order form along the fold lines so the CVS Caremark Mail Service Pharmacy address shows through the window of the envelope.

Three ways to refill:

- **Online.** You can order your mail service refills by logging on to www.caremark.com. Register online to receive refill reminders, informative newsletters and other important alerts. Have your benefit ID number handy to register.
- **Phone.** Call our toll-free Customer Care number for fully automated refill service. Have your benefit ID number ready.
- **Mail.** You will receive an order form with every prescription order. Simply fill in the ovals for the prescriptions you want to refill. If you need to refill a medication that is not listed, write in the prescription number (s) in the space provided. Send the order form to CVS Caremark and enclose your payment, if your plan requires a payment.

Sign up for mail service with FastStart®

You have several options to get started. It's easy!

- **By internet**
 1. Log in to www.caremark.com and sign in or register if necessary.
 2. Click on *Start a New Prescription* and then click on *FastStart®*.
 3. Fill in your information.
- **By phone**
 1. Call FastStart® toll free at **1.800.875.0867** Monday through Friday, 7:00 AM to 7:00 PM (CT).
 2. Let the representative know you wish to fill your prescription through mail service.
 3. Provide the representative the information on your member ID card, the names of your long-term medicines, your doctor's name and phone number, your payment information and mailing address.



Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Providers are independent contractors and are not agents of Meritain Health®. Provider participation may change without notice. Meritain Health and Aetna do not provide care or guarantee access to health services.