Instruction for Refill Prescriptions

Refill-by-Phone:

Call Caremark's Refill-by-Phone Center toll-free at 1-800-378-4408 using a touch-tone phone. You may order refills for one or more of your prescriptions — 24 hours a day. As an added feature you can also inquire on the status of any order recently submitted to Caremark.

When using the **refill-by-phone option**, you will need the following information:

- Participant Social Security number or member's I.D. number if required by your plan.
- Participants year of birth.
- 9-digit prescription number located in the box on your prescription and refill labels.
- Your VISA, MasterCard, Discover or American Express number if your plan requires a copayment.

Refill-by-Mail:

Complete sections A and B on the back of this form. Affix the Caremark refill label(s) in the space allowed.

The **Bar Code portion of the label** should be placed on the face of the envelope. For more than one refill prescription, apply only one bar code to the face of the self-addressed envelope. If a refill label is not available, write the Caremark Prescription Number in the refill label section for each prescription refill being submitted. The refill number is located in the box on your prescription and refill labels. Also enclose your copayment if applicable.

"No Refills Remain…Call Your Doctor"

If your refill label notes the above, please contact your doctor and request a new prescription.

Important Information

Whether submitting a new or refill prescription through the mail, please remember to:

- Complete all of the information in sections A and B.
- Include check, money order, or VISA, Discover, American Express or MasterCard number for copayment (if applicable).
- Enclose original prescription or affix refill labels.
- Include signature in the certification section on the back of this form.

An incomplete Participant Profile/Order Form will be returned to you with the original prescription unfilled, causing a delay in processing.

The submission of this form, for you or any of your dependents, authorizes the release of all information to applicable health care providers and all others involved in filling the prescriptions or processing the claims submitted

Caremark can not at any one time dispense more than the exact amount prescribed by your doctor or the day supply limit specified by your benefits plan, whichever is less. Caremark can not provide refills at the time of the original filling.

In connection with your benefit plan, Caremark may contact your doctor regarding your prescription. This may result in your doctor prescribing a different brand name product or a generic equivalent in place of your original prescription.

State law allows a less expensive generically equivalent drug to be substituted for certain brand name drugs unless your physician directs otherwise. You have a right to refuse such substitution. Consult your physician or pharmacist concerning the availability of a safe, less expensive drug for your use.

Please note: Consult your plan literature regarding possible differences in coverage or copayment between brands and generics.

Call Caremark Customer Service toll-free
1-800-378-4408
7:00 a.m.–9:00 p.m. Monday-Friday
8:00 a.m.–12:00 p.m. Saturday
Central Standard Time
http://www.caremark.com

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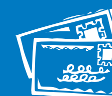
Participant Profile/ Order Form

Welcome to Caremark's mail service prescription program. This program offers a convenient, cost-effective way to order prescribed maintenance medication for direct delivery to your home or workplace. We are pleased to provide this service to you and look forward to fulfilling your prescription needs in the future.

New Prescriptions

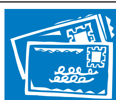
Refill-by-Phone



Refill-by-Mail

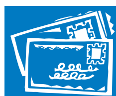
CAREMARK
PRESCRIPTION SERVICE

Affix Caremark Refill Label or Print Caremark Prescription Number



Reminder: Refills can be ordered by phone.
Call 1-800-378-4408

Affix Caremark Refill Label or Print Caremark Prescription Number



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Affix Caremark Refill Label or Print Caremark Prescription Number

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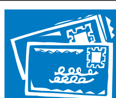

If space is needed for additional labels, please apply to any piece of paper and enclose it with this order form.

Instructions for New Prescriptions:

For new prescriptions being submitted through the mail, complete section (A) and participant information section (B). One Participant Information section must be completed for each person submitting a prescription.

A PARTICIPANT INFORMATION

Check one: ☐ Employee ☐ Retiree ☐ COBRA ☐ Medicare B

Participant Social Security Number — Plan Sponsor

Last Name — First Name — Initial

SHIP TO THIS ADDRESS:

☐ **Please check here if this is a change of address**

Street Address — Apt. or Suite — City

State — Zip Code — Daytime Phone Number — Evening Phone Number

METHOD OF PAYMENT (if applicable)

☐ Check (Payable to Prescription Service Division)
☐ Caremark Credit Memo Number ______________________
☐ Money Order or Cashier's Check
☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

Credit Card Number — Expiration Date

Signature ______________________________________

PRESCRIPTIONS ENCLOSED

Quantity of New Prescriptions __________

Quantity of Refill Labels __________

Total Quantity (New + Refill) __________

Copayment Amount Enclosed $ __________

B PARTICIPANT NO.1 INFORMATION

Last Name — First Name — Initial

Birthday — Sex ☐ Male ☐ Female — ☐ Check if this is participant's first Caremark order.

PHYSICIAN INFORMATION

Last Name — First Name — Initial

Physician's Phone Number

☐ **Please, no child-proof caps**

Drug Allergies
☐ None [10] ☐ Codeine [97] ☐ Sulfonamides [40]
☐ Aspirin [4] ☐ Penicillin [31] ☐ Other __________

Relationship to Participant
☐ Self ☐ Spouse ☐ Daughter ☐ Sponsored Dependent
☐ Son ☐ Widowed ☐ Full-time Student

Health Conditions (to determine drug/disease interactions)
☐ Arthritis [716.9] ☐ Glaucoma [365] ☐ Migraine [346.9]
☐ Asthma [493] ☐ Heart Condition [429] ☐ Osteoporosis [733]
☐ Diabetes [250] ☐ High Blood Pressure [401] ☐ Prostate Disorders [601]
☐ GERD [530.11] ☐ High Cholesterol [272.4] ☐ Thyroid [246]
☐ Other __________

PARTICIPANT NO. 2 INFORMATION

Last Name — First Name — Initial

Birthday — Sex ☐ Male ☐ Female — ☐ Check if this is participant's first Caremark order.

PHYSICIAN INFORMATION

Last Name — First Name — Initial

Physician's Phone Number

☐ **Please, no child-proof caps**

Drug Allergies
☐ None [10] ☐ Codeine [97] ☐ Sulfonamides [40]
☐ Aspirin [4] ☐ Penicillin [31] ☐ Other __________

Relationship to Participant
☐ Self ☐ Spouse ☐ Daughter ☐ Sponsored Dependent
☐ Son ☐ Widowed ☐ Full-time Student

Health Conditions (to determine drug/disease interactions)
☐ Arthritis [716.9] ☐ Glaucoma [365] ☐ Migraine [346.9]
☐ Asthma [493] ☐ Heart Condition [429] ☐ Osteoporosis [733]
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☐ GERD [530.11] ☐ High Cholesterol [272.4] ☐ Thyroid [246]
☐ Other __________

CAREMARK
3250 Meridian Parkway
Weston, FL 33331

Certification: I certify that information on this form is correct and further understand that any benefits under the Prescription Service programs are subject to my eligibility for and participation in the medical plan, and certify that I or my dependents for whom prescriptions are enclosed do not have primary prescription drug coverage under any other group medical plan. I also agree to reimburse the Plan sponsor to the extent of any benefit which is in excess of the amount payable under the medical plan.

Participant Signature ______________________ Date __________