


Mail Service Order Form

	<p>Mail this form to:</p> <p style="text-align: center;">  CVS/caremark PO BOX 106001 PITTSBURGH, PA 15230-6001 </p>
Member ID # (if not shown or if different from above) <input style="width:100%; height: 15px;" type="text"/>	
State (of Florida) Employees' Prescription Drug Plan	

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Instructions:

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:

TO RECEIVE YOUR ORDER SOONER - request refills or new prescriptions online at www.caremark.com or call toll-free 1-888-766-5490.

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

Last Name <input style="width:100%; height: 15px;" type="text"/>	First Name <input style="width:100%; height: 15px;" type="text"/>	MI <input style="width: 15px; height: 15px;" type="text"/>	Suffix (JR, SR) <input style="width:100%; height: 15px;" type="text"/>
Street Address <input style="width:100%; height: 15px;" type="text"/>	Apt./Suite # <input style="width: 30px; height: 15px;" type="text"/>	<input type="radio"/> Use shipping address for this order only.	
City <input style="width:100%; height: 15px;" type="text"/>	State <input style="width: 20px; height: 15px;" type="text"/>	ZIP Code <input style="width: 30px; height: 15px;" type="text"/> - <input style="width: 30px; height: 15px;" type="text"/>	
Daytime Phone #: <input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 40px; height: 15px;" type="text"/>	Evening Phone #: <input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 40px; height: 15px;" type="text"/>		

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B Refills. To order mail service refills, enter your prescription number(s) here.

1) _____	2) _____	3) _____	4) _____
5) _____	6) _____	7) _____	8) _____

If you need easy open caps, please make a note in the "Special Instructions" section of this form. We will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Special Instructions" section of this form. Please Note: If you request the brand-name drug when a generic is available and the doctor wrote the prescription to allow generic substitution, you will pay the brand copayment plus the difference between the cost of the brand-name drug and the cost of the generic drug.

We may package all of these prescriptions together unless you tell us not to.

All claims for prescriptions submitted to CVS Caremark Mail Service Pharmacy using this form will be submitted to your prescription benefit plan for payment.



C 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.

Spanish forms and labels

Last Name

First Name

MI Suffix (JR,SR)

Nickname

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

E-Mail Address: _____ Date new prescription written: _____

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

Tell us about new health information for 1st person if never provided or if changed.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin
 Sulfa Other: _____

Medical Conditions: 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.

Spanish forms and labels

Last Name

First Name

MI Suffix (JR,SR)

Nickname

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

E-Mail Address: _____ Date new prescription written: _____

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

Tell us about new health information for 2nd person if never provided or if changed.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin
 Sulfa Other: _____

Medical Conditions: Arthritis Asthma Diabetes Acid Reflux Glaucoma Heart Problem
 High Blood Pressure High Cholesterol Migraine Osteoporosis Prostate Issues Thyroid
 Other: _____

D Special Instructions: _____

E How would you like to pay for this order? (If your copay is \$0, you do not need to provide payment information.)

- Electronic Check.** Pay from your bank account. (You must first register online or call Customer Care.)
- Use my PayPal Credit account.** Works like a credit card. (You must first 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 expiration date.

Exp. Date MMY

Check or Money Order. Amount: \$

- Make check or money order out to CVS/caremark.
 - Write your prescription benefit ID number on your 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, PayPal Credit, 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 us to use this payment method for future orders.

Credit Card Holder Signature/Date

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

If you want faster delivery, choose:

- 2nd Business Day (\$17)** Business days are only Monday-Friday excluding national holidays.
 - Next Business Day (\$23)** Business days are only Monday-Friday excluding national holidays.
- Faster delivery charges may change.
 - Faster delivery is for shipping time only, not processing.
 - Faster delivery can only be sent to a street address, not a PO Box.



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