Mail this form to:

CVS Caremark
PO BOX 106001
PITTSBURGH, PA 15230-6001

Member ID # (if not shown or if different from above)

State of Florida Employees’ Prescription Drug Plan
Prescription Plan Sponsor or Company Name

<table>
<thead>
<tr>
<th>Instructions:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Please use blue or black ink and print in capital letters. Fill in both sides of this form.</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>A Shipping Address. To ship to an address different from the one printed above, enter the changes here.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>First Name</td>
</tr>
<tr>
<td>Street Address</td>
<td>Apt./Suite #</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Daytime Phone #:</td>
<td>Evening Phone #:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B Refills. To order mail service refills, enter your prescription number(s) here.</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1)</td>
<td>2)</td>
</tr>
<tr>
<td>5)</td>
<td>6)</td>
</tr>
</tbody>
</table>

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. If you do not want them submitted to your plan, do not use this form. You may call Customer Care to make alternate arrangements for submission of your order and payment.

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

**First person** with a refill or new prescription.

- **Last Name**
- **First Name**
- **Nickname**
- **Gender**: M F
- **Date of birth**: MM-DD-YYYY
- **Date new prescription written**: 

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

**Allergies**: None
- Aspirin
- Cephalexin
- Codeine
- Erythromycin
- Peanuts
- Penicillin
- Sulfa

**Medical conditions**: None
- Arthritis
- Asthma
- Diabetes
- Acid reflex
- Glaucoma
- Heart problem
- High blood pressure
- High cholesterol
- Migraine
- Osteoporosis
- Prostate issues
- Thyroid
- Other:

**Doctor’s last name**
**Doctor’s first name**
**Doctor’s phone #**

**Second person** with a refill or new prescription.

- **Last Name**
- **First Name**
- **Nickname**
- **Gender**: M F
- **Date of birth**: MM-DD-YYYY
- **Date new prescription written**: 

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

**Allergies**: None
- Aspirin
- Cephalexin
- Codeine
- Erythromycin
- Peanuts
- Penicillin
- Sulfa

**Medical conditions**: None
- Arthritis
- Asthma
- Diabetes
- Acid reflex
- Glaucoma
- Heart problem
- High blood pressure
- High cholesterol
- Migraine
- Osteoporosis
- Prostate issues
- Thyroid
- Other:

**Doctor’s last name**
**Doctor’s first name**
**Doctor’s phone #**

**Special instructions:**

**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.)

- **Credit or debit card.** (VISA®, MasterCard®, Discover®, or American Express®)
  - Use your card on file.
  - Use a new card or update your card’s expiration date.

  **Card number**
  **Exp. Date**

- **Check or money order.** Amount: $______ . 
  - Make check or money order payable 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 choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

- 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 takes up to 5 days after your order is processed. **If you want faster delivery, choose:**

- **2nd business day ($17)**
- **Next business day ($23)**

*(Charges subject to change)*

**Expected processing time from receipt of this form:**

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor
- Faster delivery can only be sent to a street address, not a PO Box.

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