

Fill in for up to two individuals who will receive prescriptions with this order.

#1: Easy open caps Print materials in Spanish

Last Name First Name MI Suffix (JR, SR)

Alternate Name (Nickname) Gender: M F Date of Birth:

E-mail Address: _____ Date new prescription(s) received from doctor: _____

Doctor / Prescriber's Last Name Doctor / Prescriber's First Name Doctor / Prescriber's Telephone # - -

COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

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

Health Conditions: Arthritis Asthma Diabetes GERD (Acid Reflux) Glaucoma Heart Condition
 High Blood Pressure High Cholesterol Migraine Osteoporosis Prostate Disorders Thyroid
 Other: _____

#2: Easy open caps Print materials in Spanish

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 Other: _____

Comments/Special Instructions: _____

Method of Payment/Shipping Information

Please make check or money order payable to **Caremark**. Include ID# on check/money order.

Check Money Order/Cashier's Check Voucher/Coupon Amt. of check/money order: \$

(Checks returned for insufficient funds will be subject to a processing fee of up to \$40, depending on state law.)

OR pay by credit or debit card (preferred). We accept VISA®, MasterCard®, Discover®, and American Express®.

Fill in oval to charge most recently used credit card for this order and future orders for all individuals included in the family.

Fill in oval to charge most recently used credit card for this order only.

To add, change or update your credit card information, write in below:

-

Credit/Debit Card Number Expiration Date

Credit Card Holder Signature _____ Date _____

Your credit card will be billed for prescription costs and expedited shipping (if requested).

Regular delivery is FREE (allow up to 10 days for delivery). For faster delivery, mark the appropriate oval below. Note: Expedited delivery only affects shipping time, not processing time of your order.

Fill in oval for faster delivery:

2nd Business Day = \$13 (per order) Next Business Day = \$18 (per order)

(Charges subject to change.)

By submitting this form you acknowledge that eligibility under the prescription benefit is subject to plan verification and that you/your dependents do not have primary prescription coverage under any other plan.

