

## GETTING STARTED IS JUST A PHONE CALL AWAY

And it's convenient. Just call **1.800.711.4550** (TTY: **1.800.498.5428**), 24 hours a day, 7 days a week and we'll request a new prescription from your doctor. All we need is your prescription information (medication name(s) and dosage) and the full name and phone number of your doctor.

## Ordering By Mail

If you prefer ordering by mail instead of calling, you can complete the enclosed prescription order form and return it with your prescription(s). For identification accuracy, please write your date of birth on each prescription. Just follow these step-by-step instructions to begin taking advantage of the Mail Service Pharmacy:

1. **For current medications:** Have your doctor send you a new prescription for your current maintenance medications. Be sure your doctor prescribes a 90-day supply, plus three refills.
2. **For new medications:** Have your doctor write two prescriptions: one for a 30-day supply and one for a 90-day supply plus three refills. Fill the 30-day prescription at your local pharmacy. Then once you and your doctor are confident you'll continue on this new medication, follow step 3.
3. **Mail your doctor's original prescription.** Be sure to include the confidential patient profile questionnaire also attached.

Your prescription should arrive in about 7 working days from the day your order is received. Included with your medication will be a reorder form, detailed instructions that tell you how to take the medication, possible side effects and other information. If you'd like to consult with one of our pharmacists regarding any questions or concerns, please call our Customer Service department at **1.800.711.4550** (TTY: **1.800.498.5428**), 24 hours a day, 7 days a week.

## Refills Are Even Easier

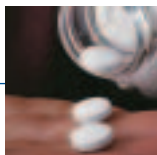
It's simple to order refills or to find out how many refills you have left. You can do this by phone, mail or over the Internet at [www.partnersrx.com](http://www.partnersrx.com). Refills are usually processed within 48 hours, and you can order three weeks before your medication runs out.

## CALL TOLL-FREE TO FIND OUT MORE

We know there are times you'll need to talk to a pharmacist about your prescriptions, so we have a licensed pharmacist on call 24 hours a day, 7 days a week.

To learn more about the Mail Service Pharmacy in general or to speak to a pharmacist, call our Customer Service department at **1.800.711.4550** (TTY: **1.800.498.5428**), 24 hours a day, 7 days a week.

For drug coverage information or general plan questions, please call the Customer Service number located on the back of your memberID card.



## Mail Service Pharmacy Order Form

Please be sure to include this order form and your original prescription(s).

Member ID #

Date of Birth

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Gender

 F  M

Last Name

First Name

MI

Delivery Address

City

State

Zip

Phone Number

--

Email Address:

Doctor Name (Last, First)

Doctor Phone Number

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### Health History

Please complete if not reported previously or a change has occurred.

#### Allergies:

- |  |   |                                     |                                       |                                       |
|--|---|-------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> No Known                      | <input type="checkbox"/> Cephalosporins     | <input type="checkbox"/> Codeine    | <input type="checkbox"/> Ampicillin   | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Sulfonamides/Sulfa | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Quinolones   |
| <input type="checkbox"/> Other (please specify): _____ |   |                                     |                                       |                                       |

#### Health Conditions:

- |  |   |                                       |   |  |
|--|---|---------------------------------------|---|--|
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cancer          |
| <input type="checkbox"/> Other (please specify): _____ |   |                                       |   |  |

Please list any Over The Counter or Herbal Medications you take regularly: \_\_\_\_\_

### Special Instructions

In order to provide you with high quality medications at the best possible price, we substitute FDA-approved generic equivalents for brand name medications whenever possible. Generic medications will not be sent if your doctor indicates a brand name medication should be dispensed.

**Please mail your completed form and prescription to the address below:**

P.O. Box 509075

San Diego, CA 92150-9075

Signature: \_\_\_\_\_