



Your Extended Family.



## CVS/caremark™ Mail Service Pharmacy Program

### User Guide

For Molina Dual Options Medicare-Medicaid Plan

### Getting started is easy!

If you need your prescription filled right away, ask your doctor to write two prescriptions for your long-term drugs:

- The first, for a short-term supply (e.g., 30 days) to be filled right away at a network retail drugstore.
- The second, for the max days' supply allowed (up to a 90-day supply) with as many as three refills (if appropriate) to be mailed to CVS/caremark.

### Ask your doctor about getting a prescription for 90-days.

Whether you use the CVS/caremark Mail Service Pharmacy Program or purchase your long-term drugs at a network retail drugstore talk to your doctor today about getting a prescription for 90 days.

### Mail service order options.

If you take one or more long-term drugs, use mail service and have them shipped to your home.

This means fewer trips to the drugstore and the gas pump.

Choose from 4 ways to order.

- **Option 1 – Mail** – Complete and mail the CVS/caremark Mail Service Order Form. Mail the form to the address printed on the form.

For new orders, don't forget to include your prescription.

- **Option 2 – Online** – Go to [www.caremark.com](http://www.caremark.com) and sign in or register by clicking on register now. Then under the prescriptions drop down menu select “start mail service” and follow either the online steps, or, feel free to complete the mail service order form and mail to CVS/caremark. The mailing address is printed on the form.
- **Option 3 – Phone** – Call CVS/caremark toll-free at (866) 830-2386, TTY 711, 24/7. Provide your Member number (found on your Plan ID card), your prescription name(s), your doctor's name and phone number, and your mailing address. You can even use the toll-free number above to order refills 24/7.



#### Your Extended Family.

- **Option 4 – Doctor** – Give your doctor’s office the CVS/caremark number, (866) 830-2386, TTY 711, and ask your doctor to call, fax, or ePrescribe your prescription 24/7. To speed up the process, your doctor will need your Member number (found on your Plan ID card), your date of birth, and your mailing address.

That’s it! Once CVS/caremark receives your order it should take about 10 days for you to receive your order.

Find out how easy it is to have prescriptions shipped to your home. You can even order refills 24/7 by calling (866) 830-2386, TTY 711. If your order does not arrive in about 10 days please call CVS/caremark at (866) 830-2386, TTY 711, 24/7.

### Refill prompts.

When using the CVS/caremark Mail Service Pharmacy Program, you can choose to receive a call, eMail, or text message advising the date you can have your prescription(s) refilled.

If you request a refill too soon alert, CVS/caremark will let you know when you can request a refill.

### Need help or have questions?

If you need help with any formulary-related issue or simply have questions about your drug benefit, please call our Pharmacy Call Center toll-free at (855) 735-5604, TTY 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

Molina Dual Options MI Health Link Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.

You can get this information for free in other formats, such as large print, braille, or audio. Call (855) 735-5604, TTY/TDD: 711, Monday - Friday, 8 a.m. to 8 p.m., EST. The call is free.

You can get this information for free in other languages. Call (855) 735-5604, TTY/TDD: 711, Monday – Friday, 8 a.m. to 8 p.m., EST. The call is free.

Puede obtener esta información gratuitamente en otros idiomas. Llame al (855) 735-5604, TTY / TDD al 711, de lunes a viernes, de 8:00 a.m. a 8:00 p.m., EST. La llamada es gratuita.

يمكنك الحصول على هذه المعلومات مجانًا بلغات أخرى. يمكنك الاتصال على الرقم (855) 735-5604، وبالنسبة لمستخدمي أجهزة الهاتف النصية / أجهزة اتصالات المعاقين: يمكنك الاتصال على 711 من الاثنين حتى الجمعة من 8:00 صباحًا حتى 8:00 مساءً كل يوم علمًا بأن المكالمات مجانية.

Limitations, restrictions, and patient pay amounts may apply. This means that you may have to pay for some services and that you need to follow certain rules to have Molina Dual Options pay for your services. For more information, call Molina Dual Options Member Services or read the Molina Dual Options Member Handbook.




**Your Extended Family.**



Benefits may change on January 1 of each year.

The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.

## Mail Service Order Form

	<p><b>Mail this form to:</b></p> <p style="text-align: center;">             CVS/caremark            PO BOX 94467            PALATINE, IL 60094-4467         </p>																			
<p>Member ID # (if not shown or if different from above)</p> <table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table>																				
<p>-----</p> <p>Prescription Plan Sponsor or Company Name</p>																				

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**Instructions:**  
 Please use **blue or black ink** and **print in capital letters**. 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](http://www.caremark.com) or call the toll-free number on your member ID card.

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

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

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CVS/caremark wants to provide you with high quality medicines at the best possible price. In order to do this, 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.

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.



**C** 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.**

Spanish forms and labels

Last Name [Grid]

First Name [Grid]

MI [ ]

Suffix (JR,SR) [Grid]

NICKNAME [Grid]

Gender: M F

Date of Birth: MM-DD-YYYY [Grid]

E-Mail Address: [Line]

Date new prescription written: [Line]

Doctor's Last Name [Line]

Doctor's First Name [Line]

Doctor's Phone # [Line]

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: [Line]

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

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

Spanish forms and labels

Last Name [Grid]

First Name [Grid]

MI [ ]

Suffix (JR,SR) [Grid]

NICKNAME [Grid]

Gender: M F

Date of Birth: MM-DD-YYYY [Grid]

E-Mail Address: [Line]

Date new prescription written: [Line]

Doctor's Last Name [Line]

Doctor's First Name [Line]

Doctor's Phone # [Line]

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: [Line]

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

**D Special Instructions:** [Line]

**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.)

**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.

[Grid]

Exp.Date MMY [Grid]

**Check or Money Order.** Amount: \$ [Grid]

Credit Card Holder Signature/Date [Line]

- 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 choose Electronic Check, PayPal Credit, or a Credit Card 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.

**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

**Next Business Day (\$23)** Monday-Friday

- 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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