MOLINA HEALTHCARE

Your Extended Family.

CVS/caremark™ Mail Service Pharmacy Program

User Guide

Molina Medicare Options Plus HMO SNP

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 to save you money!

Mail service order options.

If you take one or more long-term drugs, you may save time and money with 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 and payment to the address printed on the form. For new orders, don't forget to include your prescription.

  You can pay online from: your checking account, using Bill Me Later®, or a credit card. Or you can mail a check or money order. If you mail in a payment, do not send cash.

- **Option 2 – Online** – Go to 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) 930-7591, 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.

- **Option 4 – Doctor** – Give your doctor's office the CVS/caremark number, (866) 930-7591, 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 and payment (if required) 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) 930-7591, TTY 711. If your order does not arrive in about 10 days please call CVS/caremark at (866) 930-7591, 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 at (888) 665-1328, TTY 711, 7 Days a week, 8 a.m. – 8 p.m., local time.

Molina Medicare Options Plus HMO SNP

Molina Medicare Options Plus HMO SNP is a Health Plan with a Medicare Contract and a contract with the state Medicaid program. Enrollment in Molina Medicare Options Plus depends on contract renewal.

This information is available in other formats, such as Braille, large print, and audio.

Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-665-3086 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-665-3086 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-665-3086（TTY：711).

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

CVS caremark™

Mail Service Order Form

Mail this form to:

CVS Caremark
PO BOX 94467
PALATINE, IL 60094-4467

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

Prescription Plan Sponsor or Company Name

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 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)

Street Address | Apt./Suite #

○ **Use shipping address for this order only.**

City | State | ZIP Code

Daytime Phone #: - - Evening Phone #: - -

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

1) 2) 3) 4)

5) 6) 7) 8)

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.

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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 | 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:

Second 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.)

○ **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.

Exp.Date MMYY

Credit card holder signature/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.

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)**

Faster delivery can only be sent to a street address, not a PO Box

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

(Charges subject to change)

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