CVS/caremark Mail Service Pharmacy Program: Molina Healthcare, Senior Whole Health of New York, Passport Advantage by Molina Healthcare, My Choice Wisconsin, ConnectiCare, or Central Health Medicare Plan's Mail Order Prescription Service

You're important to us at Molina Healthcare, SWH of NY, Passport, My Choice Wisconsin, ConnectiCare, or CHMP. So, we'd like to offer you a way to save time and money with Molina Healthcare, SWH of NY, Passport, My Choice Wisconsin, ConnectiCare, or CHMP's mail order prescription service. If you take one or more medications regularly (known as *long-term drugs*), we partner with ***CVS/caremark Mail Service Pharmacy Program*** to mail them right to your home! Each order contains up to a 100-day supply per prescription. No more trips to the pharmacy or waiting in line—your medicine comes to *you*!

Receive your long-term drugs at home in 3 easy steps:

① **Make sure your drugs are available through the CVS/caremark Mail Service Pharmacy Program**

Some long-term drugs *aren't* available through mail order. Check our Formulary (List of Covered Drugs) or call our Member Services at (800) 665-3086, TTY users please call 711, October 1 – March 31: 7 days a week, 8 a.m. to 8 p.m., local time, April 1 - September 30: Monday – Friday, 8 a.m. to 8 p.m., local time to find out which ones are available.

② **Ask your doctor to write a 100-day prescription**

Talk to your doctor about the mail order prescription service. To start, your doctor will write a 100-day prescription with up to three refills (if appropriate). This is the maximum supply your doctor can prescribe.

***Note*:** If you need your drugs right away, ask your doctor for a 30-day prescription. You can fill it at a network pharmacy while you wait for your mail order to arrive.

③ **Choose one of these options to receive your orders:**

Complete the CVS/caremark Mail Service Order Form attached to this letter. Mail the completed form, payment (if required), and your 100-day prescription to the address printed on the form.

Sign up online at www.caremark.com. If this is your first time on the website, click on *Register now* to create an account. Once you log in, click Prescriptions for a drop-down menu, select *Start Mail Service* then follow the online steps.

Call CVS/caremark at (877) 581-7142, TTY: 711, 24/7. Provide your Member number (on your Plan ID), your prescription names, doctor's name and phone number, and your mailing address.

Ask your doctor to place the order for you. Their office can call, fax, or ePrescribe your prescription to CVS/caremark at (877) 581-7142, TTY: 711, 24/7. Be sure to give your doctor your Member number (on you Plan ID card), date of birth, and mailing address so they can place the order.

That's it! **Once CVS/caremark receives your order and payment (if required), your prescriptions will arrive in the mail in 10 days**. If you have any questions or if your medicine does not arrive on time, please call CVS/caremark at (877) 581-7142, TTY: 711, 24/7.

When it's time to refill your long-term drug prescription…

You can choose to receive a reminder when your long-term prescriptions need to be refilled. CVS/caremark will call, email, or text message you the date you can refill your long-term drugs. **You can place your refill order by mail, online, or by phone.** If you request a refill too soon, CVS/caremark will let you know when you *can* request a refill. Once CVS/caremark receives your refill order and payment (if required), you will receive your prescriptions in the mail in 10 days.

If you have any questions or need help with the CVS/caremark Mail Service Pharmacy Program, please call our Pharmacy Call Center at (800) 665-3086, TTY: 711, October 1 – March 31: 7 days a week, 8 a.m. to 8 p.m., local time, April 1 - September 30: Monday – Friday, 8 a.m. to 8 p.m., local time. We are here to help!

Notice of Availability (NOA)

CVS caremark®
Mail Service Order Form

Mail this form to:

CVS Caremark
PO BOX 659541
SAN ANTONIO, TX 78265-9541

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

Prescription Plan Sponsor or Company Name

Please fold here

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 _____ M Suffix (JR,SR) ___

NICKNAME ___ 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 _____ M Suffix (JR,SR) ___

NICKNAME ___ 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: _____

Please fold here →

Please fold here →

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.)

Please fold here →

Please fold here →

○ **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 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)