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.
- Members with a Low Income Subsidy (LIS) can get 3 months of tier 1,2,3, or 4 mail service or retail prescription drugs for the price of 1.

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) 467-5461, 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) 467-5461, 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) 467-5461, TTY 711. If your order does not arrive in about 10 days please call CVS/caremark at (866) 467-5461, 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 (844) 239-4913, TTY 711, 7 Days a Week 8 a.m. – 8 p.m., local time.

Molina Medicare Options Plus

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.

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.

RESET FORM

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.

Please fold here →

* WEB *

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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MOLINA HEALTHCARE

Your Extended Family.

Molina Healthcare of Idaho (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members without regard to race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. This includes gender identity, pregnancy and sex stereotyping.

To help you talk with us, Molina provides services free of charge:

- Aids and services to people with disabilities
  - Skilled sign language interpreters
  - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
  - Skilled interpreters
  - Written material translated in your language
  - Material that is simply written in plain language

If you need these services, contact Molina Member Services at (844) 239-4913; TTY/TDD: 711, Monday – Friday, 8 a.m. to 8 p.m., local time.

If you think that Molina failed to provide these services or treated you differently based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY, 711. Mail your complaint to:

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also email your complaint to civil.rights@molinahealthcare.com. Or, fax your complaint to (562) 499-0610.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can mail it to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.
If you need help, call 1-800-368-1019; TTY 800-537-7697.

MOLINA HEALTHCARE

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English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call Member Services at 1-844-239-4913 (TTY: 711).

Spanish
ATENCIÓN: Si usted habla español, tiene servicios de asistencia lingüística disponibles sin cargo alguno para usted. Llame al Departamento de Servicios para Miembros al 1-844-239-4913 (TTY: 711).

Chinese
收件人： 如果您講韓語，則免費提供語言協助服務。 請致電會員服務部，電話：1-844-239-4913 (TTY: 711).

Serbo-Croatian
PAŽNJA: ako govorite srpsko-hrvatski jezik, dostupne su vam besplatne usluge jezične pomoći. Nazovite usluge za članove na broj telefona 1-844-239-4913 (TTY: 711).

Korean
주의 : 한국어를 말할 때 무료로 언어 지원 서비스를 이용할 수 있습니다. 현지 시간으로 월요일부터 금요일까지, 오전 8시부터 오후 8시까지 회원 서비스에 1-844-239-4913 (TTY: 711).

Nepali
सावधानी: यदि तपाई नेपाली बोल्नुहुन्छ भने, भाषा सहयता सेवाहरु सित्तैमा तपाईलाई उपलब्ध छन्। 1-844-239-4913 (TTY: 711) मा सदस्य सेवाहरुको लागि कल गर्नुहोस्।

Vietnamese
LƯU Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ có sẵn cho quý vị miễn phí. Gọi cho Dịch Vụ Thành Viên theo số 1-844-239-4913 (TTY: 711).

Arabic
انتباه: إذا كنت من متحدثي اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية مجانًا. يمكن الاتصال بخدمات الأعضاء على الرقم 1-844-239-4913 (TTY: 711).

German
ACHTUNG: Für Deutsch sprechende Personen stehen kostenlose Sprachassistenzsysteme zur Verfügung. Rufen Sie hierzu die Mitgliederbetreuung unter der Rufnummer 1-844-239-4913 (TTY: 711) an.

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Tagalog
PAUNAWA: Kung gumagamit ka ng wikang Tagalog, maaari kang humingi ng mga serbisyo ng tulong sa wika nang libre. Tawagan ang Member Services sa 1-844-239-4913 (TTY: 711).

Russian
ВНИМАНИЕ! Если вы говорите по-русски, вам будут предоставлены услуги переводчика бесплатно. Позвоните в отделение обслуживания клиентов по тел.: 1-844-239-4913 (телетайп: 711).

French
ATTENTION : Si vous parlez français, des services d'assistance linguistique sont gratuitement mis à votre disposition. Contactez les services aux membres au 1-844-239-4913 (TTY: 711).

Japanese
注：日本語をお話しになる場合は、無料の言語支援サービスをご利用いただけます。メンバーサービス1-844-239-4913 (TTY: 711)までお電話ください。

Romanian
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, în mod gratuit. Apelați serviciile pentru membri la 1-844-239-4913 (TTY: 711).

Bantu
MENYA NEZA: Nimba ukoresha ururimi rw'ikibantu, ubwunganizi bw'urwo rurimi uburonswa ku buntu, . Akura abajejwe ivyo bikorwa kuri 1-844-239-4913 (TTY: 711).

Farsi
اگر به زبان فارسی صحبت می‌کنید، خدمات کمک زبانی، به صورت رایگان در دسترس شما قرار دارند. با خدمات اعضاء از طریق شماره 1-844-239-4913 (TTY: 711) تماس بگیرید.