

CVS/caremark Mail Service Pharmacy Program: Molina Healthcare's Mail Order Prescription Service

You're important to us at Molina Healthcare. So we'd like to offer you a way to save time and money with Molina Healthcare'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 90-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:

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.

Ask your doctor to write a 90-day prescription

Talk to your doctor about the mail order prescription service. To start, your doctor will write a 90-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.

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 90-day prescription to the address printed on the form.

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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 (866) 467-5442, 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 (866) 467-5442, 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 (866) 467-5442, 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!



	Mail this form to:	
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 le	tters. Fill in both sides of this form.	
New Prescriptions – Mail your new prescriptions with this form. 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	t from the one printed above, enter the changes here.	
Last Name Street Address City	First Name MI Suffix (JR, SR) Apt./Suite # Use shipping address for this order only. 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 qualit this, we will substitute equivalent generic medicines do not want us to substitute generics, please provide "Special Instructions" section of this form.	ry medicines at the best possible price. In order to do for brand name medicines whenever possible. If you e specific instructions, including drug names, in the	

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.



First person with a refill or new prescription.	○ Spanish forms and labe
Gender: () M () F Date of birth	Suffix (JR,SR)
E-mail address: Da	
Doctor's last name Doctor's first name	Doctor's phone #
Tell us about new health information for 1st person if never pr Allergies: None Aspirin Cephalosporin Codeine Sulfa Other:	<u> </u>
Medical conditions: () Arthritis () Asthma () Diabetes () Acid () High blood pressure () High cholesterol () Migraine () () Other:	
Second person with a refill or new prescription.	() Spanish forms and lab
	Suffix (JR,SR)
Gender: () M () F Date of birt	:h:
E-mail address: Da	te 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 p	<u>'</u>
Allergies: None Aspirin Cephalosporin Codeine Sulfa Other: Medical conditions: Arthritis Asthma Diabetes Acid	
Other:	Osteoporosis O Prostate issues O Thyro
Special instructions:	
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How would you like to pay for this order? (If your copay is \$0, y	ou do not need to provide payment informatio
O Electronic check. Pay from your bank account. (You must fir	st register online or call Customer Care.)
Oredit or debit card. (VISA®, MasterCard®, Discover®, or Am	erican Evnress®)
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() Use a new card or update your card's expiration date.	
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Exp. Date	Credit card holder signature/Date
Check or money order. Amount: \$	Credit card holder signature/Date
Check or money order. Amount: \$	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)
Check or money order. Amount: \$	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) Street address
Check or money order. Amount: \$	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) Faster delivery sent to a sent to

method for future orders.

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