

Mail Order Prescriptions (90 day supply)

1. The first time your doctor prescribes medication that you will take on a regular basis, ask for two prescriptions. The first prescription should be for 1 month that can be immediately filled at a participating retail pharmacy. The second should be written for a 90-day supply with refills. Use the 90-day prescription to obtain your medication from the mail order pharmacy.
2. Complete the Medco by Mail Order Form and Health, Allergy & Medication Questionnaire. Obtain the forms by calling 877-417-7345 or logging into your Prescription Drug Plan online account at www.medco.com.
3. Use the process that is most convenient for you to fill mail order prescriptions:
FAX — Give your doctor your ID number. Then have your doctor call 1-888-EASYRX1 (1-888-327-9791) to get instructions about how to fax your prescription to the pharmacy.
MAIL — Mail the order form with your prescription, payment, and questionnaire to the address on the mail order form.
4. Your prescription will arrive within 7 to 11 days.

Please take a minute to make sure...

- **You have included your doctor's signed prescription form and filled out the patient information on the front of the order form for each new prescription.**
- **You have either filled out the credit card section on the front of this order form or included a check or money order for the required co-payment.**
- **You have written your Subscriber number on any check or money order.**
- **You have filled out the Health, Allergy, and Medication Questionnaire. This information will help Medco better serve your prescription medication needs.**
- **Your prescription is written for a 90-day supply with refills.**

Medication delivery

Your medication will be delivered to you within 7 to 11 days after you mail your order.

Expedited shipping available

For an additional fee, your order will be shipped by an expedited service offered to your area. This option must be chosen when you make the order, and cannot be applied after an order is already processed.

Additional instructions

If you elect to have this and all future orders automatically charged to your credit card by checking the box on the front or enrolling by phone, bear in mind that the automated payment plan feature will apply to all mail order pharmacy orders. Also note that we can only keep one credit card on record.

You may have a balance limit on your plan account. If you do, once your unpaid balance exceeds that limit, no additional orders will be processed until the balance is paid.

You can call **1 800 948-8779** anytime to enroll in our automated payment plan, change the credit card on file, check your account balance, or pay by phone using a credit card.

Ohio law allows a less expensive, generically equivalent medication to be substituted for certain brand-name medications unless you direct or your doctor directs otherwise.

To all Medicare beneficiaries whose private health plan has elected to be billed primary for Medicare Part B covered medications:

By choosing to use Medco's mail order pharmacy to fill your prescription, you are choosing to use the prescription medication coverage provided by your group health plan. Medco will process your prescription under your group health plan coverage, independent of the Medicare program, and no claim will be submitted to Medicare. If you believe that Medicare may also provide coverage and would like Medicare to pay for your prescription, you should go to a Medicare-participating pharmacy in your area. For a list of convenient Medicare-participating pharmacies, please call your local Medicare carrier or **1-800-MEDICARE**. If you have any questions about the difference in coverage between your group health plan coverage and Medicare, please call the number on your ID card.

Health, Allergy & Medication Questionnaire



Your answers to the following questions will help us provide your pharmacy benefit services including, for example, filling prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know if you have any known allergies, conditions or diseases.

- Please complete the questionnaire for each family member enrolled in your pharmacy benefit plan.
- If you need additional forms you may call your Customer Care representative at the toll-free number listed on your ID card.
- **Return this questionnaire with your prescription or refill order form.**

SECTION 1

SUBSCRIBER IDENTIFICATION AND CONTACT

<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>
Group Number	Subscriber Number	Daytime Telephone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Primary Subscriber: First Name	M.I.	Last Name

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street Address/Apt. No.	City	State	Zip

SECTION 2

DRUG ALLERGY CONDITIONS

For each family member enrolled in the program, include his/her name, date of birth and gender. For each family member fill in the circle **ONLY** if an allergy or bad reaction happened anytime in the past. If you are allergic to a medication that is not listed, please print the name of the medication allergy in the bottom section of this chart.

Correct way to mark circles: Please use blue or black ink.

	Enrollee	Spouse	Dependent	Dependent	Dependent
First Name: Add last name if different than enrollee					
Date of Birth:					
Gender:	MM/DD/YYYY <input type="radio"/> M <input type="radio"/> F	MM/DD/YYYY <input type="radio"/> M <input type="radio"/> F	MM/DD/YYYY <input type="radio"/> M <input type="radio"/> F	MM/DD/YYYY <input type="radio"/> M <input type="radio"/> F	MM/DD/YYYY <input type="radio"/> M <input type="radio"/> F
Penicillins/cephalosporins (e.g. ampicillin, Keflex®)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tetracycline antibiotics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Erythromycin, Biaxin®, Zithromax®	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Codeine (e.g. Tylenol #3®)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-steroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aspirin (salicylates)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sulfa medications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Iodine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Print other medication allergies not listed above in the space pro- vided. Example: <i>morphine</i>					



Continue on the other side to tell us about any medical conditions.

Please list in the appropriate column the names of each family member enrolled. Then, for each family member, fill in the circle next to each condition if a doctor ever said **that particular family member** has the condition.

First Name:	Enrollee	Spouse	Dependent	Dependent	Dependent
Congestive heart failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart attack or angina	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic bronchitis or emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allergies, runny nose, hay fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood sugar (diabetes)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peptic, stomach, or duodenal ulcer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gastric reflux, heartburn, or esophagitis (GERD)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inflammatory bowel disease (colitis, Crohn's disease)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High pressure in the eyes (glaucoma)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor circulation in the legs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble with blood not clotting properly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enlarged prostate (benign prostatic hyperplasia, BPH)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraine headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Print other medical conditions not listed above in the space provided. Example: <i>glaucoma</i>					

Did you complete both sides?

Please return the questionnaire with your prescription or refill order form.

Thank You