

	Mail this form to:
Member ID # (if not shown or if different from above)  Prescription Plan Sponsor or Company Name	-
Instructions:	
Please use <b>blue or black ink, capital letters,</b> and fill in <b>both sides</b> 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 toll-free 1-800-552-8159.  A Shipping Address. To ship to an address different from the one printed above, please make 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>B</b> Refills. To order mail service refills, enter your prescription number(s) here.	
1)2)	3)4)
5)6)	7) 8)

Medicaid Members cannot choose 2<sup>nd</sup> Business Day or Next Business Day delivery options in Section E on the back of this form. Please visit your retail pharmacy if you need your prescription right away.

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 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.



