

BENEFIT INFORMATION: HealthTrans must adhere to your benefit plan. If an order cannot be processed due to benefit plan stipulations, HealthTrans will contact you. Call the Member Services phone number provided on the back of your healthcare identification card if you have questions about your drug benefits or copayments. If you have questions about placing your prescription order or your order status, call toll-free at 1-877-289-0616.

I. PATIENT INFORMATION:

Last Name M. Initial First Name
 Date of Birth / / Patient Relation to Plan Member Self Spouse Dependent Other: _____ Gender Male Female

II. SHIPPING ADDRESS

Street City
 State Zip Home Phone Work Phone

III. HEALTH INFORMATION

Known allergies, including drug allergies: Yes No If yes, please list: _____
 Medical conditions: Yes No If yes, please list: _____

IV. PRESCRIPTION BENEFIT INFORMATION

Cardholder Last Name (If different from patient) M. Initial First Name
 Member ID # Group ID #
 Group/Employer Name

V. PAYMENT OPTIONS (PAYMENT MUST ACCOMPANY ORDER)

Credit Card: MasterCard Discover Card Visa American Express
 Credit Card #: Exp. Date: _____
 Name on Card: _____
 Signature: _____ (Signature authorizes payment via method indicated above)

BILLING ADDRESS: Same as shipping address listed above

Street City
 State Zip

Check #: Amount Included: \$ _____
 Money Order #: Amount Included: \$ _____

Make check/money order payable to **HealthTrans Pharmacy**. Mail to HealthTrans, P.O. Box 4057, Greenwood Village, CO 80155-4057

VI. PRESCRIPTION INFORMATION

Please enclose any new, original prescriptions written by your physician and indicate medications below. If you need more space, list them all on a separate sheet and include it with this form:

Medication Name, Strength, Quantity	Doctor's Name	Doctor's Phone #	Refills (refill #)

- I am enclosing new original prescriptions written by my physician for the medications listed above.
- I choose to REFILL the medications that I have received from HealthTrans Pharmacy previously, using this form, or SAVE TIME by calling 1-877-839-8121

VII. PATIENT AUTHORIZATION

I certify that the information on this form is correct, and authorize release of information regarding my medical and prescription drug history to the program sponsor of the prescription drug program.

Date / / Signature: _____

INSTRUCTIONS FOR ORDERING YOUR MAINTENANCE/SPECIALTY MEDICATIONS

Welcome to the HealthTrans mail order service plan. Mail order service is designed for those patients who require medications on a recurring basis. Mail order is convenient for you because the medications will be mailed directly to your home.

Step 1 - Doctor Prescription

To begin using mail order, you must first obtain a written prescription from your doctor for a 90-day supply. Typically, only certain drugs are available for a "maintenance" 90-day prescription. Please have your doctor verify if your particular medication is 90-day eligible. The original prescription must be submitted along with the completed mail order form.

Step 2 - Fill Out Form

Take a few minutes to complete the form on the back of this page. Please fill out the order form completely and print clearly. Use one order form for each patient ordering medication(s). Missing information delays the processing of your order.

Step 3 - Select Payment Option

When using a credit card, be sure to include your credit card number and expiration date. HealthTrans Pharmacy cannot process or ship your order without payment in full. If you know your copayment, you can also pay by personal check or money order; however, these methods may delay processing. HealthTrans Pharmacy provides free standard shipping for prescriptions. If you choose to have your medication shipment rush-ordered, additional costs will apply.

Step 4 - Submit Form to HealthTrans

Send the completed form and your original prescription(s) to:
HealthTrans
P.O. Box 4057
Greenwood Village, CO 80155-4057

MEDICATION SUPPLY CONSIDERATIONS

It is standard practice to substitute generic equivalents for brand-name drugs whenever possible. HealthTrans Pharmacy will dispense an FDA-approved generic equivalent when available, permitted by your prescriber, and allowable by law. If you do not want a generic equivalent, **please call HealthTrans Pharmacy toll-free at 1-877-839-8121.**

Be sure to place your order at least 21 days before you run out of your current medication supply. If you need a prescription fulfilled immediately, ask your doctor to write a 30-day prescription that you can have filled at your local pharmacy, and a 90-day prescription for you to send to HealthTrans Pharmacy. (Please note: If your doctor specifies a quantity less than 90 days, it will be filled as written on the prescription. For example: if the prescription specifies a 30-day supply, HealthTrans Pharmacy will fill the prescription for 30 days.)

Pharmacy regulations prohibit HealthTrans Pharmacy from honoring requests to cancel or return prescription orders after the order has been received.

HIPAA - This document is covered under the guidelines and federal law regarding patient privacy information.

Refill Instructions

Thank you for ordering your prescription drugs from HealthTrans Pharmacy

To order refills of your medication, please call toll-free, 1-877-839-8121.
Please have the **Rx Number** from the drug label available (located above your name on the label)

1-800-722-1739

HEALTHTRANS
[YOUR ADDRESS]
ORIGINALLY FILLED: 05/19/05
Rx 1234567
YOUR NAME

DO NOT TAKE OTHER MEDICATIONS OR ALCOHOL WITHOUT CONSULTING YOUR PHYSICIAN OR PHARMACIST.

1-234-567-8910
DEA2101
THIS FILL: 05/19/05
SAMPLE, DOC
CJR

PRESCRIPTION USE GUIDELINES

Filed by RX.com, 4710 Mercantile Dr., Ft. Worth, TX 76137

CAUTION: Federal and/or state law prohibits transfer of this drug to any person other than the patient for whom it was prescribed.

PILL DESCRIPTION
NDC: 0007-0007-07

- Please consider HealthTrans Pharmacy for all your maintenance prescriptions.
- Please submit a new form for each new prescription from your doctor.
- Remember to keep your health conditions and allergies up to date and enclose the original prescription
- Also remember to keep your credit/debit card information current, including your name as it appears on the card and the billing zip code.
- Keep a copy for your records.