



The following contains important information about CVS Caremark Mail Service Pharmacy and how to use this valuable service.

All eligible plan participants who receive their prescriptions through CVS Caremark Mail Service Pharmacy should review this brochure.

About CVS Caremark Mail Service Pharmacy

Your prescription drug program administered by CVS Caremark includes the use of a mail service pharmacy. This convenient option lets you order medicines you take on an ongoing basis. It also may save you time and money. You can use mail service to fill prescriptions for maintenance medicines. These are drugs that you take on a regular basis, for a chronic or long-term medical condition. With CVS Caremark Mail Service Pharmacy, you will enjoy the following benefits:

- Free standard shipping to the location of your choice
- Access to a registered pharmacist 24 hours a day
- The option to refill your prescription online, by telephone or through the mail
- Up to a 90-day supply of your medicine
- Important drug and safety information with every order

How do I enroll in mail service?

1. When your doctor prescribes a maintenance medicine, ask to have the prescription written for up to a **90-day supply, or the maximum days supply allowed by your prescription drug program. Example:**
 - One per day = 90 pills
 - Two per day = 180 pillsIf your medication must be taken immediately, ask your doctor to write two prescriptions: one for a short supply to be filled at a local participating retail pharmacy, and a second for an extended supply to be mailed to CVS Caremark.
2. Examine the prescription to make sure it includes the date, dosage, your doctor's signature, and your name and address. If you need to order insulin or insulin syringes, please be sure your doctor gives you a written prescription. Mail the prescription(s) to CVS Caremark with your order form.

3. Complete the enclosed Mail Service Enrollment Form. **You only need to complete this form for your first order.** In the future, if you have additional medical information or changes to report, please notify CVS Caremark in writing.
4. Be sure to write your Member ID on the back of each prescription. Mail the completed form along with the original prescription and copayment* in the envelope provided.
5. All drugs will be delivered postage-paid to the Primary Member listed on the Enrollment Form. **A covered dependent who wishes to receive prescriptions and communications directly instead of through the Primary Member should include a request in writing with any prescription order, or submit a Confidential Communication Form available at www.caremark.com.**
6. If you have any questions concerning your order, or if you do not receive your medication in 14 days, please contact CVS Caremark toll-free at the phone number listed on your benefit ID card.

What about Generic Drugs?

The generic name of a drug is simply its chemical name. Generic drugs meet strict FDA requirements and are as safe and effective as brand-name drugs, but considerably less expensive. Generic substitutes will be dispensed whenever possible based upon availability, legal requirements and your doctor's approval.

**Copayment, coinsurance or copay means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.*

What is the process for adding new prescriptions to mail service?

For **new prescriptions**, complete the Prescription Order Form** included with each order and mail both the form and original prescription(s) to CVS Caremark Mail Service Pharmacy in the envelope provided. Be sure to write your Member ID on the back of each prescription. Your doctor can also **fax** the prescription toll-free to **1-800-323-0161**.

How do I order refills?

For refills, you have several options. You can visit our Web site at www.caremark.com to place your refill order online. In addition, you can call us at the phone number listed on your benefit ID card and provide your benefit ID, prescription number(s) and credit card information. Or, you can complete the Prescription Order Form provided with your order and mail it to CVS Caremark. Your prescription label and the Customer Receipt will indicate the number of times you may refill a medication.

When can I expect my order?

Your medication will usually be delivered within 10 to 14 days from the time CVS Caremark receives your order. To ensure timely delivery, please place your orders at least two weeks in advance to allow for mail delays and other circumstances beyond our control.

How do I pay for the prescriptions?

CVS Caremark Mail Service Pharmacy accepts checks, money orders and any of the following credit cards:

- Discover®
- MasterCard®
- Visa®
- American Express®

***Please Note: The Prescription Order Form is attached to the Customer Receipt you receive with your orders.*

How to contact us?

To get more information about mail service, please visit our Web site at www.caremark.com or call Customer Care toll-free at the phone number listed on your benefit ID card. (TDD users should dial toll-free 1-800-238-0756)

Customer Care Hours:

Monday through Friday - 24 hours a day
Saturday - 9 a.m. to 8 p.m. (ET)
Sunday - 9 a.m. to 6 p.m. (ET)

Confidential Mail Service Enrollment Form

Please make sure that each covered dependent reads the information regarding CVS Caremark Mail Service Pharmacy included with this form.

Please complete this form and return it to the following address:

CVS Caremark, P.O. Box 9062, Clearwater, FL 33758-9748

This form is read by machine. Please print the numbers and letters as shown below:

1 2 3 4 A B C D

Primary Member Information

Member ID	Date of Birth	Daytime Telephone Number (include area code)
<input type="text"/>	<input type="text"/> M M / <input type="text"/> D D / <input type="text"/> Y Y Y Y	<input type="text"/> - <input type="text"/> - <input type="text"/>
Employer / Plan Name		
<input type="text"/>		
Last Name	First Name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>
Permanent Address		
<input type="text"/>		
City	State	ZIP Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
E-mail Address		
<input type="text"/>		

Drug Allergies: <input type="checkbox"/> None <input type="checkbox"/> Erythromycin <input type="checkbox"/> Penicillin [01] <input type="checkbox"/> Aspirin [04] <input type="checkbox"/> Iodine <input type="checkbox"/> Sulfa [03]	Health Conditions: <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes [06] <input type="checkbox"/> Asthma <input type="checkbox"/> Glaucoma [07] <input type="checkbox"/> Heart Condition [08] <input type="checkbox"/> High Blood Pressure [09] <input type="checkbox"/> Hypertension <input type="checkbox"/> Thyroid-Low/High [05]	<input type="checkbox"/> Other / diabetic supplies _____
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Dependent 1	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Drug Allergies: <input type="checkbox"/> None <input type="checkbox"/> Iodine <input type="checkbox"/> Aspirin [04] <input type="checkbox"/> Penicillin [01] <input type="checkbox"/> Codeine <input type="checkbox"/> Sulfa [03]
	Last Name <input type="text"/>	
	First Name <input type="text"/> MI <input type="text"/> Date of Birth <input type="text"/> M M / <input type="text"/> D D / <input type="text"/> Y Y Y Y	
	Health Conditions: <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes [06] <input type="checkbox"/> Glaucoma [07] <input type="checkbox"/> Heart Condition [08] <input type="checkbox"/> High Blood Pressure [09] <input type="checkbox"/> Hypertension <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Thyroid-Low/High [05]	
<input type="checkbox"/> Other / diabetic supplies _____		

Dependent 2	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Drug Allergies: <input type="checkbox"/> None <input type="checkbox"/> Iodine <input type="checkbox"/> Aspirin [04] <input type="checkbox"/> Penicillin [01] <input type="checkbox"/> Codeine <input type="checkbox"/> Sulfa [03]
	Last Name <input type="text"/>	
	First Name <input type="text"/> MI <input type="text"/> Date of Birth <input type="text"/> M M / <input type="text"/> D D / <input type="text"/> Y Y Y Y	
	Health Conditions: <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes [06] <input type="checkbox"/> Glaucoma [07] <input type="checkbox"/> Heart Condition [08] <input type="checkbox"/> High Blood Pressure [09] <input type="checkbox"/> Hypertension <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Thyroid-Low/High [05]	
<input type="checkbox"/> Other / diabetic supplies _____		

Prescription Order Form For New Participants

The enclosed prescriptions, if any, are for: (check all that apply)

Member Spouse Dependent

Please write the member number on the back of each prescription and **remember to include the prescription from the prescriber in the envelope.**

Payment Information - Credit Card

To authorize payment by credit card, provide the account number, expiration date and cardholder's signature. We accept Discover, MC, VISA and AMEX. **This card will be used for this and all future orders, unless we are notified otherwise.**

Credit Card Number

Expiration Date M M / Y Y

Cardholder Signature _____ Date _____

PLEASE READ AND SIGN TO COMPLETE THIS FORM

I certify that the information provided on this form is correct and the prescriptions enclosed are for covered participants, and I authorize the release of this information to the Plan Sponsor, administrator or underwriter.

NOTICE: All communications, including the mailing of prescriptions, will be directed to the Primary Member on the Enrollment Form. A covered dependent who wishes to receive prescriptions and communications directly instead of through the Primary Member should include a request in writing with any prescription order, or submit a Confidential Communication Form available at www.caremark.com.

Primary Member Signature _____ Date _____

Payment Information - Check or Money Order

Please make check or money order payable to **CVS Caremark. Do not send cash.**

Total Amount Enclosed

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