

# Home Delivery Service: Worry-free prescriptions with home delivery

CVS Caremark® offers a convenient option for receiving prescription drugs that you take on an ongoing basis. You can have a 90-day supply of prescription maintenance medication sent directly to your home, office, or other location that works for you.

With home delivery service from CVS Caremark, your medicine arrives safely at your door in plain packaging — at no extra cost to you. We also let you know when a shipment is on the way so you can make changes or cancel at any time.

## Convenience

- Medicine is delivered directly to you, which means fewer trips to the pharmacy
- Mail Service is a hassle-free switch: we contact your doctor for a 90-day prescription of your current medicine
- Sign-up one time and you are set
- Manage your prescriptions and track orders 24/7 at **Caremark.com**

## Safety

- All prescriptions are reviewed by a pharmacist to help ensure your order is complete and accurate
- Medicine arrives in private, tamper-resistant and when needed, temperature-controlled plain packaging



## Get started today

### Online:

- Go to **Caremark.com/mailservice**.
- **Register** or **Sign In** and have your member ID number ready.
- Follow the guided steps to request a prescription. Once we have your information, we will contact your doctor for a 90-day prescription of your current medicine.

### Phone:

- Call the toll-free number at 1-888-624-1139 (TTY 711), 24 hours a day, seven days a week.
- Be ready with: your member ID number, list of long-term medications, doctor's information and payment method.
- Your doctor can also call in your prescription with the information from your member ID card, date of birth and mailing address.

### Mail:

- Fill out and send a mail service form.
- Be sure to include your original prescription from your doctor for up to a 90-day supply.

**Caremark.com**

# Mail Service Order Form

Mail this form to:



CVS Caremark  
PO BOX 94467  
PALATINE, IL 60094-4467

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 letters**. Fill in **both sides** 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](http://www.caremark.com) or call toll-free 1-888-624-1139. TTY 711, 24 hours a day, 7 days a week.

**A Shipping Address.** To ship to an address different from the one printed above, enter the 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 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 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.



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**C Tell us about the people ordering prescriptions.** If there are more than two people, please complete another form.

**First person** with a refill or new prescription.

Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender:  M  F

Date of birth: MM-DD-YYYY

E-mail address: \_\_\_\_\_ Date new prescription written: \_\_\_\_\_

Doctor's last name

Doctor's first name

Doctor's phone #

Tell us about new health information for 1st person if never provided or if changed.

Allergies:  None  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfa  Other: \_\_\_\_\_

Medical conditions:  Arthritis  Asthma  Diabetes  Acid reflux  Glaucoma  Heart problem  High blood pressure  High cholesterol  Migraine  Osteoporosis  Prostate issues  Thyroid  Other: \_\_\_\_\_

**Second person** with a refill or new prescription.

Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender:  M  F

Date of birth: MM-DD-YYYY

E-mail address: \_\_\_\_\_ Date 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 provided or if changed.

Allergies:  None  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfa  Other: \_\_\_\_\_

Medical conditions:  Arthritis  Asthma  Diabetes  Acid reflux  Glaucoma  Heart problem  High blood pressure  High cholesterol  Migraine  Osteoporosis  Prostate issues  Thyroid  Other: \_\_\_\_\_

**D Special instructions:** \_\_\_\_\_

**E How would you like to pay for this order?** (If your copay is \$0, you do not need to provide payment information.)

**Electronic check.** Pay from your bank account. (You must first register online or call Customer Care.)

**Credit or debit card.** (VISA®, MasterCard®, Discover®, or American Express®)

Use your card on file.

Use a new card or update your card's expiration date.

CARD NUMBER

Exp. Date MMY Y

**Check or money order.** Amount: \$ \_\_\_\_\_ . \_\_\_\_\_

• Make check or money order payable to CVS Caremark.

• Write your prescription benefit ID number on your check or money order.

• If your check is returned, we will charge you up to \$40.

**Payment for balance due and future orders:** If you choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

Credit card holder signature/Date

**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 can only be sent to a street address, not a PO Box

**Next business day (\$23)**

**Expected processing time from receipt of this form:**

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor (Charges subject to change)



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