1800 Center Street
Camp Hill, PA 17089

Your Mail Order Pharmacy Information

Dear Member:

Thank you for your interest in mail order pharmacy. If you take medication on an ongoing basis, mail order pharmacy may save you time and money. Plus, you'll enjoy the convenience of having the prescriptions delivered right to your home. Standard shipping is free.

Express Scripts®, the nation's largest pharmacy benefit manager, administers our mail order pharmacy benefit. To get started:

1. Ask your doctor to write a prescription for up to a 90-day supply, plus refills for up to one year, if appropriate.
2. Complete the enclosed pharmacy Mail Order Form and Health, Allergy & Medication Questionnaire.
3. Send the completed forms and your payment to the address listed on the mail order form.

If you have Internet access, be sure to register to use the member website. Go to the website listed on your ID card, click on the Register link and follow the directions to get a username and password. After logging in, take advantage of features such as these:

- Find covered medications
- Price a medication
- View your mail order status
- Learn about a prescription drug
- Get refill reminders

Feel free to call the member service number on the back of your ID card if you have questions or need additional assistance due to a disability or limited English proficiency.

Sincerely,

Highmark Blue Shield

Enclosures

Express Scripts Pharmacy℠
Home Delivery Form

EXPRESS SCRIPTS®

1 Member information: Please verify or provide Member information below.

Member ID: _____
Group: ***HRKHCRE***
Name: _____
Street Address: _____
Street Address: _____
Street Address: _____
City, ST, ZIP: _____
Daytime phone:
Evening phone:

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:
_____@_____.____

☐ New shipping address:

_____

_____

_____

(Express Scripts will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.)

FOLD HERE

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in the envelope provided.

First name _____ Last name _____

Birth date (MM/DD/YYYY) Sex ☐ M ☐ F Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name _____ 1st initial Doctor's phone number

First name _____ Last name _____

Birth date (MM/DD/YYYY) Sex ☐ M ☐ F Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name _____ 1st initial Doctor's phone number

FOLD HERE

3 Complete your order: You can pay by e-check, check, money order or credit card. Make checks and money orders **payable to Express Scripts,** and write your member ID number on the front. You can enroll for e-check payments using the website on the back of your member ID card or call **1-800-903-6228.**

Number of prescriptions sent with this order:

Payment options: ☐ e-check ☐ Payment enclosed ☐ Credit card ☐ Send bill

For credit card payments:
☐ Visa ☐ MC ☐ Discover ☐ AmEx ☐ Diners

Credit card number

Expiration date
M M Y Y

X _____
Cardholder signature

☐ I authorize Express Scripts to charge this card for all orders from any person in this membership.

☐ Rush the mailing of this shipment ($21, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

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Mailing instructions are provided on the back of this form.

Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

FOLD HERE

Important reminders and other information

Check that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective and less expensive generic drugs.

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

You authorize release of all information to the plan administrator, underwriter, sponsor and their agents for use in connection with the benefit plan programs. Information may also be used for other reporting and analysis purposes without identification of you or your family members.

Express Scripts will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise.

☐ Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise. **Check the box if you do not wish a less expensive brand or generic drug.**

Please note that this applies only to new prescriptions and to any refills of that prescription.

For additional information or help, please refer to the website listed on the back of your member ID card or call Member Services at 1-800-903-6228. TTY/TDD users should call 1-800-759-1089.

For Refills

To order refills please refer to the website listed on the back of your member ID card. Have your member ID number and prescription (Rx) number on hand. Your 12-digit prescription or Rx number can be found on your refill slip.

To order by phone: Call **1-800-473-3455** to use the automated refill system. Have your member ID number and refill slip with the prescription information ready.

Federal law prohibits the return of dispensed controlled substances. In addition, pharmacies cannot reuse or re-dispense medications that have been returned.

FOLD HERE

ID No: <<XXXXXXXXXXXX>>

Group No: <<XXX>>

EXPRESS SCRIPTS
PO BOX 747000
CINCINNATI, OH 45274-7000

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Health, Allergy & Medication Questionnaire (HMQ)

EXPRESS SCRIPTS®

Your answers to the following questions will help us provide your prescription drug benefit services, including 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 person in the household eligible for pharmacy benefits through the Express Scripts Pharmacy℠.
- If you need additional forms you may call your Member Service toll-free number on the back of your member ID card.
- **Return this questionnaire with your prescription or refill order form.**

Section 1: Member Identification and Contact

Group Number

Member Number
(Located on your current ID card or in your benefits information)

Area Code
Daytime Telephone Number

Member/Subscriber First Name

M.I.

Last Name

Street Address/Apt. No.

City

State

Zip

Section 2: Drug Allergy Conditions

For each covered family member, include their 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 your medication 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.

	Member	**Spouse**	**Dependent**	**Dependent**	**Dependent**
First Name:					
Add last name if different than member					
Date of Birth:	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Gender:	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F
Penicillin/cephalosporin Antibiotics (e.g., ampicillin, Keflex®)	○	○	○	○	○
Tetracycline antibiotics	○	○	○	○	○
Erythromycin, Biaxin®, Zithromax®	○	○	○	○	○
Codeine (e.g., Tylenol #3®)	○	○	○	○	○
Non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen)	○	○	○	○	○
Aspirin (e.g., salicylates)	○	○	○	○	○
Sulfa drugs	○	○	○	○	○
Iodine	○	○	○	○	○
Print other drug allergies not listed above in the space provided (e.g., morphine)					

Continued on back

Section 3: 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 that condition.

First Name:	Member	Spouse	Dependent	Dependent	Dependent
Heart failure (weak heart)	○	○	○	○	○
High blood pressure (hypertension)	○	○	○	○	○
Heart attack or angina	○	○	○	○	○
High cholesterol (hypercholesterolemia)	○	○	○	○	○
Stroke	○	○	○	○	○
Chronic bronchitis or emphysema (COPD)	○	○	○	○	○
Asthma	○	○	○	○	○
Allergies, runny nose, hay fever (allergic rhinitis)	○	○	○	○	○
High blood sugar (diabetes)	○	○	○	○	○
Thyroid disease	○	○	○	○	○
Peptic, stomach, or duodenal ulcer	○	○	○	○	○
Gastric reflux, heartburn, or esophagitis (GERD)	○	○	○	○	○
Inflammatory bowel disease (colitis, Crohn's disease)	○	○	○	○	○
High pressure in the eyes (glaucoma)	○	○	○	○	○
Seizures	○	○	○	○	○
Poor circulation in the legs (peripheral vascular disease)	○	○	○	○	○
Trouble with blood not clotting properly	○	○	○	○	○
Enlarged prostate (benign prostatic hyperplasia, BPH)	○	○	○	○	○
Arthritis	○	○	○	○	○
Osteoporosis	○	○	○	○	○
Depression	○	○	○	○	○
Migraine headaches	○	○	○	○	○
Print other medical conditions not listed above in the space provided (e.g., cancer)					

Did you complete both sides?

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

Thank you very much.

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