Highmark Blue Cross Blue Shield
120 Fifth Avenue Place
Pittsburgh, PA 15222-3099

HIGHMARK. | EXPRESS SCRIPTS®

Welcome to your new prescription drug benefit

Dear Member:

Welcome to the Highmark prescription drug benefit, administered by Express Scripts. The clinical expertise and state-of-the-art technology of Express Scripts helps to make it the nation's leading pharmacy benefit manager.

Your plan offers the time savings and convenience of having your covered prescriptions delivered right to you. Your medications will be dispensed by one of the pharmacists in the Express Scripts network of mail-order pharmacies.

The enclosed materials cover the many features of your prescription drug plan:

- **"Your Highmark Blue Cross Blue Shield Mail-Order Pharmacy"** brochure, which explains your prescription drug benefit and offers simple instructions on how to take full advantage of all the prescription services.
- A **mail-order form** for mailing in your first prescription to the **Medco Pharmacy®** (mail order), now a part of the Express Scripts family of pharmacies.
- A **Health, Allergy & Medication Questionnaire** to help safeguard you against potentially harmful medication-related problems. *Please complete and return this form along with the mail-order form using the enclosed preaddressed envelope.*

If you have Internet access, you can visit us online at **www.highmarkbcbs.com**. After registering, you can access information about your benefit as well as health and wellness resources. Or you may contact Highmark Member Service toll-free at the number on the back of your member ID card. We look forward to meeting all of your prescription drug benefit needs.

Sincerely,

Highmark Blue Cross Blue Shield

P.S. Please remember to return the **Health, Allergy & Medication Questionnaire** in the preaddressed return envelope. It's important to your health and safety.

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Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield companies.

Express Scripts is an independent company that administers pharmacy services.

Medco Pharmacy®
MAIL-ORDER FORM
(Now a part of the Express Scripts family of pharmacies)

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

Member ID:
Group: PD1 BCWP001
Name:
Street Address:
Street Address:
Street Address:
City, ST, ZIP:

☐ 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.)

Daytime phone:
Evening phone:

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 and price medications at **www.highmarkbcbs.com**, 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 the shipment ($15, 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, visit us at **www.highmarkbcbs.com** or call Member Service at 1-800-903-6228. TTY/TDD users should call 1-800-759-1089.

For Refills

To order from our website: **www.highmarkbcbs.com**. 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

Program: *PRG1582-2*

Place your prescription(s), this form, and your payment in the envelope provided. Be sure the address shows through the window. Do not use staples or paper clips.

MEDCO HEALTH SOLUTIONS OF FORT WORTH
PO BOX 650022
DALLAS, TX 75265-9867

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Health, Allergy & Medication Questionnaire (HMQ)

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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 Medco Pharmacy®**, now a part of the Express Scripts family of pharmacies.
- If you need additional forms, you may call your Highmark Member Service toll-free number, or you may print a form online at **www.highmarkbcbs.com**.
- **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 benefit 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®)	○	○	○	○	○
Nonsteroidal 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)					

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

Did you complete both sides?

Thank you very much.

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