PrimeMail® New Prescription Order Form

Mail this form to: PrimeMail, PO Box 16190
Pittsburgh, PA 15242-0190

For faster refills: Visit **www.MyPrimeMail.com**
or call 866.260.0487, 24 hours a day, 7 days a week; TTY Users 711

CARD HOLDER INFORMATION

Card Holder's ID

Card Holder's Date of Birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

Card Holder's Last Name

Card Holder's First Name

MI

Patient's Last Name (if different than card holder's last name)

Patient's First Name

MI

Patient's Gender: ○ Male ○ Female

Patient's Date of Birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

Patient's Phone Number (☐☐☐) ☐☐☐-☐☐☐☐

Patient's Permanent Address

City

State

ZIP Code

Patient's E-mail Address

Contact by: ○ E-mail ○ Phone

DRUG ALLERGIES

○ None ○ Codeine ○ Sulfa
○ Aspirin ○ Erythromycin ○ Penicillin
○ Other _____

HEALTH CONDITIONS

○ Arthritis ○ Diabetes ○ Glaucoma ○ High cholesterol
○ Asthma ○ Depression ○ Heart condition ○ Hypertension
○ Other _____

PATIENT'S NEW PRESCRIPTIONS

Drug Name	Physician/Prescriber's Name & Phone Number	Mark if brand requested*
		○
		○
		○

Total Number of New Prescriptions: _____

Mail the original physician-signed prescriptions with this completed form. For multiple dependents please use multiple forms. If more than 3 prescriptions are needed, write the requested information from this table on a separate piece of paper and enclose with your order. If you do not wish to have one of the medications filled, please indicate on the prescription to save for future fill or to not fill at all. Additional processing time may be required for prescriptions that require physician clarification.

*Pharmacy law may permit pharmacists to substitute a less expensive FDA-approved generically equivalent medication for a brand-name medication unless you or your prescriber indicate otherwise. Some health plans require the patient to pay the difference between generic and brand name cost.

CONTINUED ON BACK

SHIPPING INFORMATION

○ **Regular:** No charge ○ **Second business day:** $15* ○ **Next business day:** $22* *** Additional costs charged to you.**

Shipping time does not include processing time. Shipping prices are subject to change.

We are unable to ship second business day or next business day orders to P.O. boxes.
Shipping address must be a physical location.

Alternate Shipping Address (if different than permanent address)

City State Zip Code Phone Number

○ This is a change of address ○ This is a one time address ○ Seasonal address from _____ to _____

PAYMENT INFORMATION

Payment is due with each order and may be made by credit card, check or money order.
Orders received without payment may delay processing. There is a $20 returned check charge.

Check or money order
Please make check or money order payable to Prime Therapeutics and include your member ID on the memo line. Do not send cash.

○ Check ○ Money Order

Credit card information
To authorize payment by credit card, provide the account number, expiration date and signature. We accept Discover, MasterCard, VISA and American Express. This card will be used for this and all future orders unless we are notified otherwise.

Credit Card Number Expiration Date

○ Use credit card on file, with the last 4 digits of:

Signature _____ Date _____

By returning this form to PrimeMail, you consent to the release and use of the patient's health information to the patient's health plans and health care providers/agents for health benefits management. Prime Therapeutics use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources such as medical providers; shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

PrimeMail may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product.

PrimeMail® is a registered trademark of Prime Therapeutics LLC.

PrimeMail® Refill Order Form

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Card Holder's First Name

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Patient's Last Name (if different than card holder's last name)

Patient's First Name

MI

Patient's Gender: ○ Male ○ Female

Patient's Date of Birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

Patient's Phone Number (☐☐☐) ☐☐☐–☐☐☐☐

Patient's Permanent Address

City

State

ZIP Code

Patient's E-mail Address

Contact by: ○ E-mail ○ Phone

DRUG ALLERGIES

○ None ○ Codeine ○ Sulfa
○ Aspirin ○ Erythromycin ○ Penicillin
○ Other _____

HEALTH CONDITIONS

○ Arthritis ○ Diabetes ○ Glaucoma ○ High cholesterol
○ Asthma ○ Depression ○ Heart condition ○ Hypertension
○ Other _____

REFILL BY MAIL

Note: For new prescriptions, fill in patient name and prescribing information and mail the original physician-signed prescription with this completed form.

Prescription	Patient Name	Physician or Prescriber's Name/Phone Number/Drug Name	Prescription Numbers (for refills only)
1			
2			
3			

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○ Check ○ Money Order

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