

MAIL SERVICE PHARMACY

An Easier Way To Get Your Medications

PacifiCare can't put an end to errands, but we can cross one off your list! The Prescription Solutions[®] Mail Service Pharmacy can eliminate your frequent trips to the pharmacy to refill your maintenance medications. No more waiting until the last minute because you can order refills three weeks ahead of time. No more waiting in lines – after all, aren't there other things you'd rather be doing? Giving you more free time is just one benefit of this service offered to you by PacifiCare.

It's Easy To Start

You can receive a 90-day supply of your medication through Mail Service, rather than just a 30-day supply from your local pharmacy.

Just follow these step-by-step instructions to begin taking advantage of the Prescription Solutions[®] Mail Service Pharmacy.

- 1. For current medications** – Have your doctor send you a new prescription for your current maintenance medications. Your doctor should prescribe a 90-day supply, plus refills.
- 2. For new medications** – Have your doctor write two prescriptions: one for a 30-day supply and one for a 90-day supply plus refills. Fill the 30-day prescription at your local pharmacy. Then, once you and your doctor are confident that you'll continue on this new medication, follow step 3.
- 3. Mail your doctor's original prescription for a 90-day supply, along with your payment.** Be sure to include the confidential patient profile questionnaire also attached.

Your prescription will arrive within 10 to 14 working days. Included with your medication will be a reorder form, detailed instructions that tell you how to take the medication, possible side effects and other information. We also include the toll-free number that connects you to our registered pharmacists, so you can call with any questions.

State/Region Code

- PLH**
California
- PLA**
All Other States

*Only complete for your first order or if your information has changed.
Mail to: Prescription Solutions, P.O. Box 509075, San Diego, CA 92150-9075.*

Complete this form. Please make checks payable to Prescription Solutions. To allow us to monitor for potential drug interactions, indicate any drug allergies, health conditions or chronic diseases on reverse side. Please print or type.

Please Select Method of Payment – Do Not Send Cash – Enclose Copayment for Each Prescription Ordered

Check or money order (Payable to Prescription Solutions) **–or–** Credit Card (Select one) Mastercard VISA DISCOVER AMEX

Credit Card#: _____ Exp. Date (mm/yy): _____ Card Holder Name: _____
PRINT NAME

Number of Prescriptions Enclosed: _____ Total Amount Enclosed: \$ _____
SIGNATURE

ID Number

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PHYSICIAN NAME: _____ PHYSICIAN PHONE NUMBER: _____

YOUR NAME: _____ GROUP NAME: _____

ADDRESS: _____ CITY: _____ STATE/ZIP: _____

I hereby certify the information on this form is correct. I assume financial responsibility for charges not payable or allowable by PacifiCare. Payment in excess of amount due should be applied to my account balance. I permit Prescription Solutions[®] to release all information to plan sponsor, administrator or underwriter.

Signed: _____ Phone: (____) _____ Date: _____
REQUIRED DAYTIME PHONE

