

PrimeMail® New Prescription Order Form



Mail this form to: PrimeMail, P.O. Box 660319 Dallas, TX 75266-0319



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CARD HOLDER INFORMATION	N	
Card Holder's ID	Card Holder's Date of Birth(mm/do	/уууу)
Card Holder's Last Name	Card Hole	der's First Name MI
Patient's Last Name (if different that	an card holder's last name) Patient's First Name	MI
Patient's Gender: () Male () Fema	Patient's Date of Birth (mm/dd/yyyy) Patien	t's Phone Number
Patient's Permanent Address]
City	State ZIP Cod	
Patient's E-mail Address	Co	ntact by: () E-mail () Phone
DRUG ALLERGIES	HEALTH CONDITIONS	
O None O Codeine O Sul	Ifa Arthritis Diabetes Glaucon	na () High cholesterol
O Aspirin O Erythromycin O Per	nicillin () Asthma () Depression () Heart co	ndition () Hypertension
Other	Other	
PATIENT'S NEW PRESCRIPTION	ONS	
Drug Name	Physician/Prescriber's Name & Phone Number	Mark if brand requested*
		0
		0
		0
Total Number of New Prescript	ions:	
multiple forms. If more than 3 pre- separate piece of paper and encl	prescriptions with this completed form. For multipescriptions are needed, write the requested informose with your order. If you do not wish to have on to save for future fill or to not fill at all. Addition quire physician clarification.	nation from this table on a e of the medications filled,

*Pharmacy law permits pharmacists to substitute a less expensive FDAapproved 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.

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- IN THE IN ORMATION	
○ Regular: No charge ○ Second business day: \$15* ○ No	ext business day: \$22* * Additional costs charged to you.
Shipping time does not include processing time. Shipping price	es good through 1/1/2009.
We are unable to ship second business day or next business day of Shipping address must be a physical location.	orders to P.O. boxes.
Alternate Shipping Address (if different than permanent address)	
City State ZIP Code	Phone Number (
① This is a change of address ① This is a one time address	O Seasonal address from to
PAYMENT INFORMATION	
Payment is due with each order and may be made by credit card, Orders received without payment will delay processing. There is	•
Check or money order Please make check or money order payable to Prime Therapeutic and include your member ID on the memo line. Do not send cash	
Credit card information To authorize payment by credit card, provide the account numb Discover, MasterCard, VISA and American Express. This card will be are notified otherwise.	
Credit Card Number Expiration Da	te
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.

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