



## **PrimeMail® Pharmacy Ordering Instructions**

Please PRINT in CAPITAL letters using black ink only. Fill in the applicable ovals completely (●). Questions? Visit our web site at **www.bcbsfl.com** or call PrimeMail Pharmacy at 888.849.7845, TTY/TTD:711; Monday – Friday, 8:00 a.m. to 12:00 a.m. EST; Saturday and Sunday, 8:30 a.m. to 9:00 p.m. EST.

Preguntas? El registro sobre nuestro sitio del web en **www.bcbsfl.com** o llame la farmacia de PrimeMail en 888.849.7845, TTY/TTD:711; Monday – Friday, 8:00 a.m. to 12:00 a.m. EST; Saturday and Sunday, 8:30 a.m. to 9:00 p.m. EST.

### **MEMBER HISTORY SECTION**

Information is required only on the first order unless there is a change in health status. Indicate all known allergies, conditions or other current medications by filling in the corresponding oval that matches the description. Please contact your physician if you are unsure about any of this information.

### **PAYMENT SECTION**

Payment is due with each order and may be made by credit card, check or money order. Credit card is the only payment option for faxed orders and offers greater member convenience. There is a \$20 returned check charge. Do not send cash. Orders received without payment will delay processing. Any outstanding balances will be the responsibility of the primary insured. If you have questions about your payment amount, call PrimeMail Pharmacy Member Services at 888.849.7845, TTY/TTD:711; Monday – Friday, 8:00 a.m. to 12:00 a.m. EST; Saturday and Sunday, 8:30 a.m. to 9:00 p.m. EST.

### **PRESCRIPTION SECTION**

For **NEW** prescriptions you may use either:

- **MAIL** — Mail the original physician-signed prescription (ask for the maximum-days supply) with the order form to: **PrimeMail Pharmacy, P.O. Box 660319, Dallas, TX 75266-0319**
- **FAX** — Your physician must fax both pages of this completed form, along with your prescription(s), to 888.214.1811; orders not faxed from a licensed physician's office will not be processed (fax orders must use credit card payment)

For **REFILL** prescriptions you may use:

- **WEB**— Log on to **www.bcbsfl.com** and follow the instructions
- **PHONE**— Call our automated refill line, 7 days a week 24 hours a day, at 888.849.7845 or TTY/TTD:711; Monday – Friday, 8:00 a.m. to 12:00 a.m. EST; Saturday and Sunday, 8:30 a.m. to 9:00 p.m. EST; and follow the system prompts
- **MAIL** — Mail the order form with the refill information completed to: **PrimeMail Pharmacy, P.O. Box 660319, Dallas, TX 75266-0319**

**MEMBER HISTORY SECTION**

Member ID Number (on face of member ID card)

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Member Last Name

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Sex: M F

Member First Name

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MI

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Birth Date (MM/DD/YYYY)

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PCN

**M E D D P R I M E**

Member Phone Number

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Delivery Address

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Zip Code

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Email Address

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**PAYMENT SECTION**

Payment by check or money order  
(Make payable to Prime Therapeutics LLC and write your member ID number on the memo line.)

Payment by credit card (Provide information below)  
 MasterCard  Visa  American Express  Discover

Credit Card Number

□□□□□□□□□□□□□□□□

Expiration Date (MM/YY)

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Your credit card will be charged for drug costs, expedited shipping (if requested) and any outstanding balances due.

**Credit Card Holder's Signature**

**DELIVERY SECTION**

Delivery date does not include prescription processing time. Please choose your shipping method.

- Regular - no charge
- Second Business Day (\$9)\*
- Next Business Day (\$15)\*

If you've chosen Second Business Day or Next Business Day shipping, no P.O. boxes will be accepted

\*Additional costs charged to you

**CONTINUED ON BACK** ➔



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**PRESCRIPTION SECTION**

ALLERGIES							CONDITIONS							
<input type="radio"/> None Known	<input type="radio"/> Aspirin	<input type="radio"/> Codeine	<input type="radio"/> Penicillin	<input type="radio"/> Sulfa	<input type="radio"/> Tetracycline	<input type="radio"/> Other Allergy*	<input type="radio"/> None Known	<input type="radio"/> Diabetes	<input type="radio"/> Epilepsy	<input type="radio"/> Glaucoma	<input type="radio"/> Heart Condition	<input type="radio"/> Hypertension	<input type="radio"/> Ulcer	<input type="radio"/> Other Condition*

\*Please detail "other allergy" or "other condition" for member referenced above, including related medications: \_\_\_\_\_

Prescription	Physician Name/Phone Number (for new prescriptions only)	Prescription Numbers (for refills only)							
1									
2									
3									

If more than three prescriptions are needed, write the requested information from this table on a separate piece of paper and enclose with your order.

**PrimeMail Pharmacy staff may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically-appropriate product. PrimeMail Pharmacy will dispense FDA-approved generic equivalents when available and appropriate.**

Some health plans require the patient to pay the difference between generic and brand name cost. State law allows pharmacist to substitute a less expensive generically equivalent drug for a brand drug unless you or your physician directs otherwise.

Do you want the generic?       Yes (if available and your doctor permits)       No

**By returning this form to PrimeMail, you consent to the use and release of your health information to your 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 the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).**

