Prime THERAPEUTICS Pharmacy™

Home Delivery Order Form

1 Member and physician information

Please use black or blue ink. One form per member.

Member ID number		Gender ☐ M ☐ F
Last name	First name	MI
Delivery address		Apt. #

City	State	ZIP Code
Date of birth / /	Email address	
Physician name	Physician phone number ( )	

Phone number (list in order of preference) (circle one)

(_______) ______________________ M H W

(_______) ______________________ M H W

(_______) ______________________ M H W

Best time to be reached: a.m. p.m.

2 Health history

Drug allergies:

☐ Amoxil/Ampicillin
☐ Aspirin
☐ Cephalosporins
☐ Codeine
☐ Erythromycin
☐ NSAIDs
☐ Penicillin
☐ Quinolones
☐ None known
☐ Sulfa
☐ Tetracyclines
☐ Others: ____________

Health conditions:

☐ Arthritis
☐ Asthma
☐ Cancer
☐ Diabetes
☐ Glaucoma
☐ Heart condition
☐ High blood pressure
☐ High cholesterol
☐ None known
☐ Osteoporosis
☐ Thyroid disease
☐ Others: ____________

List all prescription, over-the-counter and herbal drugs taken regularly: (use additional sheet if necessary)

3 Refills

To order home delivery refills, enter your prescription number(s):

1: ____________ 2: ____________ 3: ____________ 4: ____________

5: ____________ 6: ____________ 7: ____________ 8: ____________

4 Pharmacy processing

Generic substitution: FDA-approved generic equivalents will be dispensed for brand-name drugs whenever possible, unless you or your physician indicate otherwise. Brand-name drugs may be subject to a higher cost. Generic equivalents are usually less expensive than brand-name drugs. If we dispense a brand-name drug, you may be responsible for a higher copay and/or the difference between the brand and generic price of each drug. If allowed by your prescriber, we will dispense a generic equivalent unless you check this box. ☐ I do not accept a generic equivalent.

Keep on file: If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them here:

Notes to pharmacy:
BIN/PCN/RxGRP = 017449/YALE/PRXYAL

5 Payment and shipping information

Do not send cash.

Standard delivery is included at no charge. Most prescription orders arrive within seven days from the date your order is received. We will contact you if there is an extended delay in delivering your medicine. Please call **800.424.8274 (TTY 711)** if you have any questions. Once shipped, medicine may not be returned for a refund or adjustment. Visit **PrimeTherapeutics.com/PatientForms** to download additional order forms.

☐ Ship overnight (additional charges will apply). Please call to verify pricing. No P.O. Box overnight shipping.

☐ Check enclosed. All checks must be signed and made payable to Prime Therapeutics Pharmacy.

☐ Charge to my new credit card.

☐ Charge to my credit card on file.

I authorize Prime Therapeutics Pharmacy to charge the following amount to my credit/debit card without prior notification:
________ up to $150 ________ up to $250 ________ up to $ ________ (other amount greater than $250)

For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance and other such expenses related to prescription orders. By supplying my credit card number, I authorize Prime Therapeutics Pharmacy to maintain my credit card on file as payment method for any future charges. To modify payment selection, customer service can be contacted at any time at **800.424.8274 (TTY 711)**.

Cardholder signature:	Date:

Credit card number (VISA®, MasterCard®, Discover® or American Express® are accepted) and expiration date (month/year)

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐ / ☐☐☐☐

6 Complete your order form

Mail this completed order form with your new prescription(s) to Prime Therapeutics Pharmacy, P.O. Box 620968, Orlando, FL 32862. DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.

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