



New Prescription Order Form



Horizon Blue Cross Blue Shield of New Jersey



Mail this form to: PrimeMail® PO Box 16342 Pittsburgh, PA 15242-0342

For faster service: Visit www.MyPrimeMail.com or call 888.844.3828 TTY 711

Llame la farmacia de PrimeMail en 888.844.3828 o el registro sobre nuestro sitio del web en www.MyPrimeMail.com

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

Table with 3 columns: Drug Name, Physician/Prescriber's Name & Phone Number, Do not fill at this time

Total Number of 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. Additional processing time may be required for prescriptions that require physician clarification. For prescriptions to be filled at a later date, call the customer service number above to activate.

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 PO 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 \_\_\_\_\_

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.

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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