



**Fill in for up to two individuals who will receive prescriptions with this order.**

**#1:**  Easy open caps  Print materials in Spanish  
Last Name  First Name  MI  Suffix (JR, SR)

Alternate Name (Nickname)  Gender:  M  F Date of Birth:  -  -

E-mail Address:  Date new prescription(s) received from doctor:

Doctor / Prescriber's Last Name  Doctor / Prescriber's First Name  Doctor / Prescriber's Telephone #  -  -

**COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED**

**Allergies:**  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfonamides/Sulfa  
 None  Other:

**Health Conditions:**  Arthritis  Asthma  Diabetes  GERD (Acid Reflux)  Glaucoma  Heart Condition  
 High Blood Pressure  High Cholesterol  Migraine  Osteoporosis  Prostate Disorders  Thyroid  
 Other:

**#2:**  Easy open caps  Print materials in Spanish  
Last Name  First Name  MI  Suffix (JR, SR)

Alternate Name (Nickname)  Gender:  M  F Date of Birth:  -  -

E-mail Address:  Date new prescription(s) received from doctor:

Doctor / Prescriber's Last Name  Doctor / Prescriber's First Name  Doctor / Prescriber's Telephone #  -  -

**COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED**

**Allergies:**  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfonamides/Sulfa  
 None  Other:

**Health Conditions:**  Arthritis  Asthma  Diabetes  GERD (Acid Reflux)  Glaucoma  Heart Condition  
 High Blood Pressure  High Cholesterol  Migraine  Osteoporosis  Prostate Disorders  Thyroid  
 Other:

Comments/Special Instructions:

**Method of Payment/Shipping Information**

Please make check or money order payable to **Caremark**. Include ID# on check/money order.

Check  Money Order/Cashier's Check  Voucher/Coupon **Amt. of check/money order:** \$  .

(Checks returned for insufficient funds will be subject to a processing fee of up to \$40, depending on state law.)

OR pay by credit or debit card (preferred). We accept VISA®, MasterCard®, Discover®, and American Express®.

**Check oval to charge most recently used credit card for this order and future orders for all individuals included in the family.**

**Check oval to charge most recently used credit card for this order only.**

To add, change or update your credit card information, write in below:

-    
Credit/Debit Card Number Expiration Date

Credit Card Holder Signature Date

Your credit card will be billed for prescription costs and expedited shipping (if requested).

**Regular delivery is FREE** (allow up to 10 days for delivery).  
For faster delivery, mark the appropriate oval below.  
Note: Expedited delivery only affects shipping time, not processing time of your order.

**Check oval for faster delivery:**

2nd Business Day = \$13 (per order)  Next Business Day = \$18 (per order)  Check  
(Charges subject to change.)

By submitting this form you acknowledge that eligibility under the prescription benefit is subject to plan verification and that you/your dependents do not have primary prescription coverage under any other plan.

