

C Tell us about the people getting prescriptions. If there are more than two people, please complete another form.

1st person with a refill or new prescription. This person needs:

Spanish forms and labels

LAST NAME

FIRST NAME

M Suffix (JR,SR)

NICKNAME

Gender: M F

Date of Birth: MM-DD-YYYY

Your E-Mail: _____ Date new prescription written: _____

Doctor's Last Name

Doctor's First Name

Doctor's Phone #

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin Sulfa Other: _____

Health Information: Arthritis Asthma Diabetes Acid Reflux Glaucoma Heart Problem High Blood Pressure High Cholesterol Migraine Osteoporosis Prostate Issues Thyroid Other: _____

2nd person with a refill or new prescription. This person needs:

Spanish forms and labels

LAST NAME

FIRST NAME

M Suffix (JR,SR)

NICKNAME

Gender: M F

Date of Birth: MM-DD-YYYY

Your E-Mail: _____ Date new prescription written: _____

Doctor's Last Name

Doctor's First Name

Doctor's Phone #

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin Sulfa Other: _____

Health Information: Arthritis Asthma Diabetes Acid Reflux Glaucoma Heart Problem High Blood Pressure High Cholesterol Migraine Osteoporosis Prostate Issues Thyroid Other: _____

D Special Instructions: _____

E How would you like to pay for this order? (If your copay is \$0, you do not need to provide payment information.)

Electronic Check. Pay from your bank account. First time users register online or call Customer Care.

Bill Me Later®. Works like a credit card. First time users register online or call Customer Care.

Credit or Debit Card. (VISA®, MasterCard®, Discover®, or American Express®)

Fill in this oval to use your card on file.

Fill in this oval to use a new card or to update your card expiration date.

CARD NUMBER Exp. Date MMY Y

Check or Money Order. Amount: \$ _____

- Make check or money order out to CVS Caremark.
- Write your prescription benefit ID number on your check or money order.
- If your check is returned, we will charge you up to \$40.

Payment for Balance Due and Future Orders: If you chose Electronic Check, Bill Me Later®, or a Credit or Debit Card, we will also use it to pay for any balance that you owe and for future orders.

Fill in this oval if you **DO NOT** want to use this payment method for future orders.

Credit Card Holder Signature/Date

Regular delivery is free and will take up to 10 days from the day you send this form.

If you want faster delivery, choose:

- 2nd Business Day (\$17)** Business days are only Monday-Friday
- Next Business Day (\$23)** Monday-Friday

- Faster delivery charges may change.
- Faster delivery is for shipping time, not processing time.
- Faster delivery can only be sent to a street address, not a PO box.



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