

ScripPharmacy is a valuable component of your prescription benefit. Why? Because by using ScripPharmacy, you'll receive certain advantages that only mail service has to offer.

Try it and you'll see!

- Order up to a 90-day supply of your medication
- Put an end to waiting in long lines at your local pharmacy
- Avoid having to remember to reorder your prescription every month
- Have your medication shipped directly to your home, office or vacation spot
- Take advantage of our Customer Service Department available to assist you 24 hours-a-day
- Choose from convenient ordering options including phone, internet, fax & mail

Ask your Doctor for a 90-day Prescription

Why does it benefit you to request a 90-day supply?

For one, you don't have to place your order over and over again each month. Instead, order just once every three months. More importantly, you'll save money. Rather than paying for the prescription 3 times over a 3 month period, you'll pay for the 90-day quantity just once!

Request a Generic

Next time your doctor writes you a prescription, ask if a generic version of the drug is available. Generic drugs are completely safe and choosing them saves you money. (Note: When generic is available and your prescription requires a brand, you pay the generic copay, *plus* the full difference in cost between the brand and generic.)

Ready to place an order? It's easy!

Either fill out the attached patient profile form, enclose it with your actual prescription, and mail it to:

ScripPharmacy
Dept C
P.O. Box 1778
Columbus, OH 43272-5410

- or -

Go to www.ScripPharmacy.com, create an account, and enter in your prescription order online through our simple 3-step ordering process. (Note: Your physician will be contacted to verify your prescription. Before using online ordering, you may wish to confirm your physician's availability by phone to verify prescriptions.)

If at any time you have questions while trying to place an order, call ScripPharmacy's Customer Service at [800-677-4323](tel:800-677-4323).

Need a refill?

After you have placed your first order and are ready for a refill, you can do one of the following:

- Order your refill at www.ScripPharmacy.com
- Call our 24-hour refill line at [800-926-2455](tel:800-926-2455) and be sure to have your Rx number available
- Mail us the [prescription re-order form](#) in the postage-paid envelope that came with your last order

Additionally, once you have ordered through ScripPharmacy and we have your account on file, you can direct your doctor to our special physician lines. Your doctor can fax your prescription to [800-205-7408](tel:800-205-7408) or call it in to [800-677-4323](tel:800-677-4323).

TO ORDER BY MAIL: Complete this form and return along with your prescriptions and copayment to:
ScripPharmacy, Dept C, P.O. Box 1778, Columbus, OH 43272-5410

Insured's Name: _____ Member ID#: _____

Plan Name: _____ SSN: _____ Group No. _____

Ship To: CHECK HERE IF NEW ADDRESS OR PHONE NO. Home Ph. (____) _____ Daytime Ph. (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Number of Prescriptions Enclosed: _____ X \$ _____ Copay = \$ _____ Check or money order enclosed

Bill my credit card: AMEX VISA MasterCard Discover Card No: _____

Cardholder Signature: _____ Exp. Date: _____

Prescriptions Enclosed for: _____ Number of Rxs Enclosed: _____

Name: _____ ID# _____

Relationship to insured: Insured Spouse Child Sex: Female Male Date of Birth: _____

This information is required by Federal and State Law, and will be used exclusively by the pharmacists of ScripPharmacy in order to more effectively manage your prescription drug therapy. All information is considered confidential.

Patient Profile

Health Conditions

Drug Allergies

	Acne	Anxiety	Arthritis	Asthma	Heart Condition	High Blood Pressure	Glaucoma	HIV/AIDS	Epilepsy	Aspirin	Codeine	Penicillin	Sulfa	NONE
Insured's Full Name														
Eligible Spouse's Full Name														
Dependent's Full Name														
Dependent's Full Name														
Dependent's Full Name														

Other Allergies _____

Other Health Conditions _____

Other Medications Being Taken _____

Please list names of all physicians providing care (include dentists, podiatrists, eye doctors, etc.) and their telephone numbers:

Physician Name	Physician Phone	Specialty

I certify that the information on this form is correct, and authorize release of all information regarding my family's or my own medical and prescription drug history and treatment to the Plan Sponsor and to ScripPharmacy.

Signature _____ **Date** _____