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How to use your online home delivery service forms:

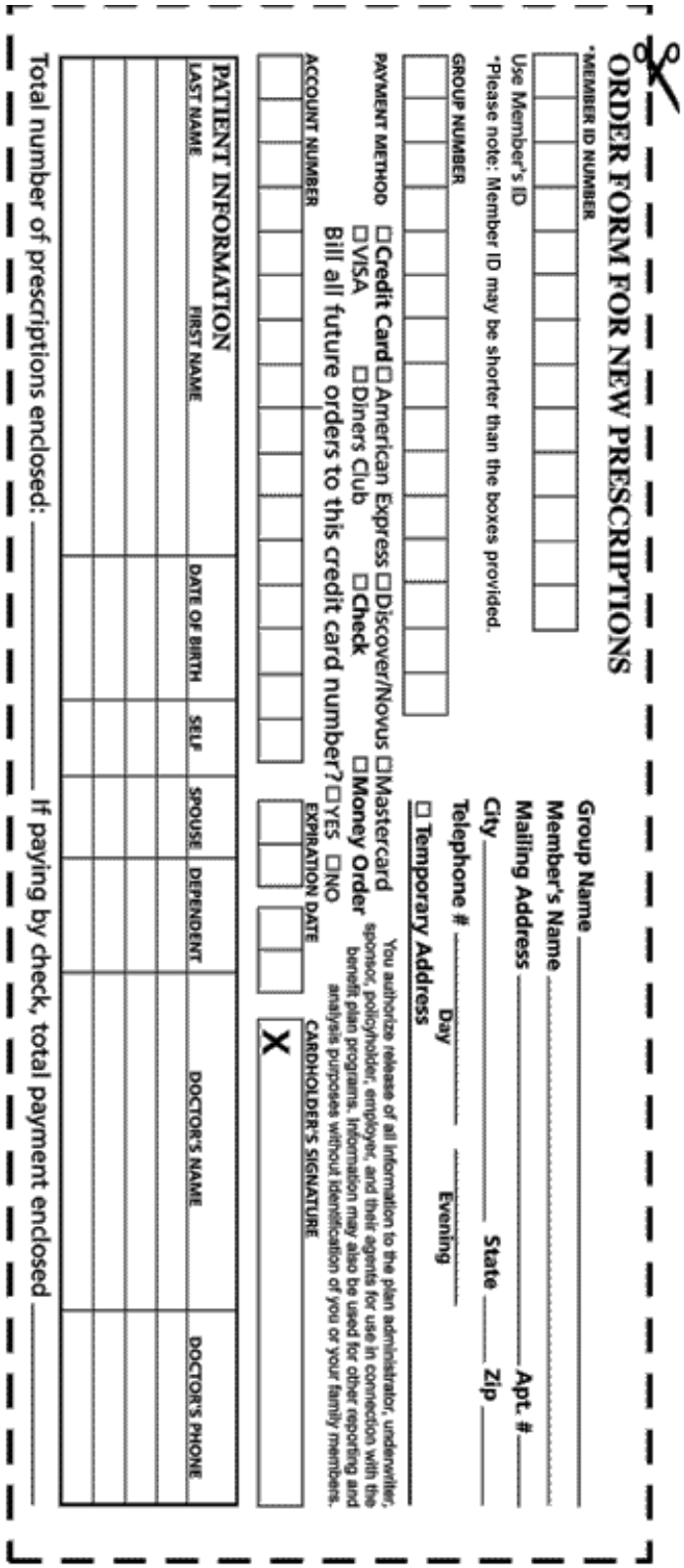
1. Print the Order Form for the New Prescription and the Health, Allergy & Medication Questionnaire (HAQ).

2. Once the forms are printed, be sure to complete all information areas in full. ***Please remember to include the HAQ if this is your first order*** or if there has been a change you need to let the pharmacist know about.

3. Cut the Order Form for New Prescriptions along the dotted lines where indicated, and place both forms, along with your new or renewal prescription from your doctor into a standard, white, business-size #10 envelope.

4. Write or type the address of your home delivery pharmacy on the front of the envelope and mail to Medco Health Solutions.

Please Note: Your medication will be delivered to you within 6 to 10 days after you mail your order. Therefore, when placing your order, you should have at least a 14-day supply of that medication on hand.



ORDER FORM FOR NEW PRESCRIPTIONS

*MEMBER ID NUMBER

Use Member's ID

*Please note: Member ID may be shorter than the boxes provided.

GROUP NUMBER

Group Name

Member's Name

Mailing Address

Apt. #

City State Zip

Telephone # Day Evening

☐ Temporary Address

PAYMENT METHOD ☐Credit Card ☐American Express ☐Discover/Novus ☐Mastercard ☐VISA ☐Diners Club ☐Check ☐Money Order

Bill all future orders to this credit card number? ☐YES ☐NO

ACCOUNT NUMBER

EXPIRATION DATE

You authorize release of all information to the plan administrator, underwriter, sponsor, policyholder, employer, and their agents for use in connection with the benefit plan programs. Information may also be used for other reporting and analysis purposes without identification of you or your family members.

X

CARDHOLDER'S SIGNATURE

PATIENT INFORMATION

LAST NAME	FIRST NAME	DATE OF BIRTH	SELF	SPOUSE	DEPENDENT	DOCTOR'S NAME	DOCTOR'S PHONE

Total number of prescriptions enclosed: _____ If paying by check, total payment enclosed _____

Health, Allergy & Medication Questionnaire

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Your answers to the following questions will help us provide your pharmacy benefit services including, for example, filling prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know if you have any known allergies, conditions or diseases.

- Please complete the questionnaire for each person in the household eligible for pharmacy benefits with Medco Health Home Delivery Pharmacy Service™.
- If you need additional forms you may call your Member Services toll free number.
- **Please remember to print your group and member number on both pages**.
- **Return this questionnaire with your prescription or refill order form**.

Section 1: Member Identification and Contact *(Group and Member number required on all pages)*

Group Number | **Member Number** *(Located on your pharmacy benefit card and/or in your benefits information)* | **Daytime Telephone Number**

Member/Subscriber First name | **M.I.** | **Last Name**

Street Address/Apt No. | **City** | **State** | **Zip**

Section 2: Drug Allergy Conditions

For each covered family member, include their first name, date of birth and gender.
For each family member fill in the circle **ONLY** if an allergy or bad reaction happened anytime in the past.
If your allergy is not listed, please print the name of the medication allergy in the bottom section of this chart.

Correct way to mark circles: ● ***Please use blue or black ink.***

Please add last name if different than member	**Member**	**Spouse**	**Dependent**	**Dependent**	**Dependent**
First Name:					
Date of Birth (MM/DD/CCYY):					
Gender:	O **M** O **F**	O **M** O **F**	O **M** O **F**	O **M** O **F**	O **M** O **F**
Penicillin/Cephalosporin Antibiotics (e.g. ampicillin, Keflex®)	O	O	O	O	O
Tetracycline Antibiotics	O	O	O	O	O
Erythromycin, Biaxin®, Zithromax®	O	O	O	O	O
Codeine (e.g Tylenol #3)	O	O	O	O	O
Non-steroidal anti-inflammatory (NSAID) drugs (e.g. Ibuprofen)	O	O	O	O	O
Aspirin (e.g. Salicylates)	O	O	O	O	O
Sulfa drugs	O	O	O	O	O
Iodine	O	O	O	O	O
If there is a drug allergy to report and not listed above, please print the name of the drug in the space. Example: *Morphine* →					

Group Number

Member Number

Section 3: Medical Conditions

Please list names of each family member enrolled in the appropriate column. Then for each family member, fill in the circle next to each condition if a doctor ever said ***that particular family member*** has any of the following conditions.

	Member	Spouse	Dependent	Dependent	Dependent
First Name:					
Heart Failure (weak heart)	O	O	O	O	O
High blood pressure (**hypertension**)	O	O	O	O	O
Heart attack or angina	O	O	O	O	O
High cholesterol (**hypercholesterolemia**)	O	O	O	O	O
Stroke	O	O	O	O	O
Chronic bronchitis or emphysema (**COPD**)	O	O	O	O	O
Asthma	O	O	O	O	O
Allergies, runny nose, hay fever (**allergic rhinitis**)	O	O	O	O	O
High blood sugar (**diabetes**)	O	O	O	O	O
Thyroid disease	O	O	O	O	O
Peptic, stomach or duodenal ulcer	O	O	O	O	O
Gastric reflux, heartburn or esophagitis (**GERD**)	O	O	O	O	O
Inflammatory bowel disease (**colitis, Crohn's disease**)	O	O	O	O	O
High pressure in the eyes (**glaucoma**)	O	O	O	O	O
Seizures	O	O	O	O	O
Poor circulation in the legs (peripheral vascular disease)	O	O	O	O	O
Trouble with blood not clotting properly	O	O	O	O	O
Enlarged prostate (benign prostatic hyperplasia, **BPH**)	O	O	O	O	O
Arthritis	O	O	O	O	O
Osteoporosis	O	O	O	O	O
Depression	O	O	O	O	O
Migraine headaches	O	O	O	O	O
Print other medical conditions not listed above in the space provided. Example - *Glaucoma* →					

For more information about Medco Health, please visit us online at **www.medcohealth.com**.

Please complete both pages and staple together.

Please return the questionnaire with your prescription or refill order form.

Thank you very much.