

# Welcome to your Mail Service Pharmacy Benefit Program

## Welcome to your Express Scripts mail pharmacy benefit program

Express Scripts mail service pharmacy program offers many unique features, including mail service, exceptional customer service, and innovative clinical features. We look forward to managing your mail service pharmacy needs.

### Here's how the mail service program benefits you

**QUALITY**—Our mail service pharmacies use state-of-the-art dispensing systems that help our pharmacists provide quality care for participants needing maintenance medications.

**CONVENIENCE**—With the Express Scripts mail service program, you receive fast, convenient delivery of maintenance medications delivered directly to your home.

**COST MANAGEMENT**—The Express Scripts program manages your care by managing costs. When you fill or refill your prescription by mail, you pay only your copayment. Through our mail service program, you can order a prescription supply determined by your benefit plan.

**Express Scripts, Inc.**  
P.O. Box 52171  
Phoenix, AZ 85072-9907

*Please see other side for instructions on how to use our mail service.*

Please complete both sides, detach and mail this form in envelope provided

XMB/SHP

### Member Information

Sierra Member ID/SSN #		Company name		
Last name	First name	Middle Initial	Sex	
Mailing address				Apt. or Suite
City	State	Zip		
( )		( )		
Birthdate (mo/day/yr)	Daytime Phone #	Evening Phone #		

### Check one:

- HPN                       SHO  
 SHL                       Senior Dimensions

### Check all that apply:

- |   |  |
|---|--|
| <b>Health Conditions</b>                                | <b>Drug Allergies</b>                      |
| <input type="checkbox"/> Asthma (493.90)                | <input type="checkbox"/> none              |
| <input type="checkbox"/> Arthritis (714.00)             | <input type="checkbox"/> Aspirin (03)      |
| <input type="checkbox"/> Diabetes (250.01)              | <input type="checkbox"/> Codeine (04)      |
| <input type="checkbox"/> Depression (311.00)            | <input type="checkbox"/> Erythromycin (09) |
| <input type="checkbox"/> Glaucoma (365.90)              | <input type="checkbox"/> Iodine (29)       |
| <input type="checkbox"/> HighCholesterol (272.0)        | <input type="checkbox"/> Penicillin (01)   |
| <input type="checkbox"/> Hypertension (402.90)          | <input type="checkbox"/> Sulfa (15)        |
| <input type="checkbox"/> Thyroid (245.90)    HG (242.9) | <input type="checkbox"/> LW(244.9)         |

### Other health conditions or drug allergies:

I prefer "easy open" caps  Yes  No

**To realize cost savings, we will dispense FDA approved generic medications when allowed by your physician, subject to the terms outlined in your plan design.**

Credit Card Number                      Expiration date

Signature

### Method of Payment

- Check (Payable to Express Scripts, Inc.)  
 Money Order or Cashier's Check  
 VISA       MasterCard       Discover Card

**For new mail service prescriptions, please follow these simple steps:**

1. If you need to start your medication right away, have your physician complete two prescriptions. Please be sure the prescription from your physician is legible, includes the drug's name, strength, the quantity to dispense, the exact daily dosage, the physicians' name, phone number and the physician's DEA number.
2. Fill one prescription immediately at a pharmacy and submit the other to the Express Scripts, Inc. mail service program for a supply determined by your benefit plan. Encourage your physician to write your prescription for the maximum days supply covered by your benefit plan. This will help you maximize your benefit and save money.
3. Complete the mail service participant profile. Please be sure to write your participant ID number in the space provided on the profile. **Your ID number is generally your social security number.** If your benefit plan includes dependent coverage, please fill out the dependent section(s), even if you are not ordering medications for them at this time. If more space is needed for dependents, please list them on a separate sheet.
4. Mail the participant profile, original prescription(s) and copayment (if applicable) to Express Scripts,

Inc. in the reply envelope provided. If your plan requires a percentage copayment, please include your credit card information on the patient profile or you will receive an invoice for the amount you owe. You can expect delivery of your order within 14 days from the date your order is postmarked. Refill orders will take 14 days to receive.

**Please note: A complete street address is required for controlled substance medications and an adult signature is required upon receipt.**

**For refill prescriptions:**

When you receive your first prescription, you will receive a prescription refill slip, if applicable, and a prescription request card. Please follow the refill instructions to order a refill. Remember to order your refill prescription at least three weeks before your current supply runs out.

**Customer Service**

The Customer Service Call Center is available 24-hours-a-day, 365-days-a-year.

**The Customer Service Associates can help you:**

- Answer questions about your benefit plan
- Assist you in ordering a refill prescription

Our Customer Service Associates handle millions of calls each year. With the call center, you'll find that prompt, world class service is just a phone call away.

**TOLL FREE: 1-888-618-8258**

**TDD/TTY: 1-800-305-5376**

**Dependent #1**  Spouse  Child

\_\_\_\_\_  
Last name

\_\_\_\_\_  
First name Middle Initial

\_\_\_\_\_  
Birthdate (mo/day/yr) Sex

**Other health conditions and drug allergies:**

**Physician Information**

\_\_\_\_\_  
Last name First name ( ) Phone #

**Health Conditions**

- Asthma (493.90)
- Arthritis (716.90)
- Diabetes (250.0)
- Depression (311)
- Glaucoma (365.9)
- High Cholesterol (272.0)
- Hypertension (401.9)
- Thyroid (245.90)
- High (242.9)
- Low (244.9)

**Drug Allergies**

- None
- Aspirin (03)
- Codeine (04)
- Erythromycin (09)
- Iodine (29)
- Penicillin (01)
- Sulfa (15)

**Dependent #2**  Spouse  Child

\_\_\_\_\_  
Last name

\_\_\_\_\_  
First name Middle Initial

\_\_\_\_\_  
Birthdate (mo/day/yr) Sex

**Other health conditions and drug allergies:**

**Physician Information**

\_\_\_\_\_  
Last name First name ( ) Phone #

**Health Conditions**

- Asthma (493.90)
- Arthritis (716.90)
- Diabetes (250.0)
- Depression (311)
- Glaucoma (365.9)
- High Cholesterol (272.0)
- Hypertension (401.9)
- Thyroid (245.90)
- High (242.9)
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**Drug Allergies**

- None
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