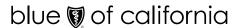


New Prescription Order Form



CARD HOLDER INFORMATION

Mail this form to: PrimeMail® PO Box 27836 Albuquerque, NM 87125-7836 For added service:

Visit www.MyPrimeMail.com or call 866.346.7200 TTY 886.346.7197

Llame la farmacia de PrimeMail en 866.346.7200 o el registro sobre nuestro sitio del web en www.MyPrimeMail.com

Card Holder's ID	Card Holder's Date of Birth (mm/dd/yyyy)						
Card Holder's Last Name		Card Holder's First Name MI					
Patient's Last Name (if different than ca	rd holder's last name) Patient's F	irst Name MI					
Patient's Gender: () Male () Female	Patient's Date of Birth (mm/dd/yyyy)	Patient's Phone Number					
Patient's Permanent Address							
City	State	Zip Code					
Patient's E-mail Address		Contact by: () E-mail () Phone					
DRUG ALLERGIES	HEALTH CONDITIONS						
O None O Codeine O Sulfa	O Arthritis O Diabetes	○ Glaucoma ○ High cholesterol					
○ Aspirin ○ Erythromycin ○ Penie	illin () Asthma () Depression	○ Heart condition ○ Hypertension					
Other	Other						
PATIENT'S NEW PRESCRIPTIONS	<u>'</u>						
Drug Name Phy	sician/Prescriber's Name & Phone Num	ber Do not fill at this time					
		0					
		0					
		0					
Total Number of Prescriptions:		-					

Mail the original physician-signed prescriptions with this completed form. For multiple dependents please use multiple forms. If more than 3 prescriptions are needed, write the requested information from this table on a separate piece of paper and enclose with your order. Additional processing time may be required for prescriptions that require physician clarification. For prescriptions to be filled at a later date, call the customer service number above to activate.

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SHIPPING INFORMATION						
Regular: No charge	Second business day	y: \$15*	Next bus	siness day: \$22'	*Additional costs charged to you.	
Shipping time does not include	le processing time. S	Shipping pri	ces are su	bject to change.	i	
We are unable to ship second b	usiness day or next b	usiness day o	orders to Po	O boxes.		
Shipping address must be a phy	sical location.					
Alternate Shipping Address (if di	fferent than permaner	nt address)				
City	State	Zip Code		Phone Number		
① This is a change of address	① This is a one ti	me address	() Sea	sonal address fro	om to	
PAYMENT INFORMATION						
Payment is due with each order a may delay processing. There is			eck or mon	ey order. Orders	received without payment	
Check or money order Please make check or money or include your member ID on the include the second			s and	() Check	() Money Order	
Credit card information To authorize payment by credit card, provide the account number, expiration date and signature. We accept Discover, MasterCard, VISA and American Express. This card will be used for this and all future orders unless we are notified otherwise.						
Credit Card Number		Expiration I	Date			
O Use credit card on file, with the	e last 4 digits of:					

Pharmacy law may permit pharmacists to substitute a less expensive FDA-approved generically equivalent medication for a brand-name medication unless you or your prescriber indicate otherwise. Some health plans require the patient to pay the difference between generic and brand name cost.

Date

By returning this form to PrimeMail, you consent to the release and use of the patient's health information to the patient's health plans and health care providers/agents for health benefits management. Prime Therapeutics' use or disclosure of individually identifiable health information, whether furnished by you or obtained from other sources such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

PrimeMail may contact your physician for clarification and safety purposes, which may result in your physician prescribing a different, clinically appropriate product.

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PrimeMail is a registered trademark of Prime Therapeutics LLC.

Signature