

INSTRUCTIONS:

Please read the following carefully before completing the order form.

WHAT IS THE MAIL SERVICE PRESCRIPTION DRUG PROGRAM?

The mail service prescription drug program is a home delivery prescription drug service. The program is designed mainly for individuals using maintenance medication for the treatment of long-term conditions, such as, but not limited to, diabetes, arthritis, heart conditions and high blood pressure. Your specific plan design describes the maximum supply you can receive.

WHAT IS COVERED?

The program covers drugs which by federal law require a doctor's prescription and is covered by your medical plan. Certain drugs are not available through mail service.

Please refer to your Benefit Plan Summary for your copayment, maximum days supply and specific drug coverage exclusions.

Note: Insulin and insulin syringes require a prescription when ordered through the Blue Cross of California Mail Service Program.

WHO IS ELIGIBLE?

If you and your family are presently covered for outpatient prescription drugs under your prescription benefit plan, you are eligible to enroll in the home delivery program.

HOW DO I USE THE PROGRAM THE FIRST TIME?

1. When your doctor prescribes a maintenance drug, have the prescription written for up to a 60 day supply with up to five (5) refills or a 90 day supply with up to three (3) refills. By law, prescriptions can only be filled with the quantity indicated by your doctor and allowed by your pharmacy benefit design. Example: 1 a day = 60 pills; 2 a day = 120 pills
(Refer to your Benefit Plan Summary for the maximum day supply allowed by your plan.)
2. Complete the attached Enrollment/Order Form for New Participants and Confidential Patient Profile for you and your covered family members. **This form will need to be completed with your first order only.**
In the future, if you have additional medical information or changes to report, please notify the Blue Cross of California Mail Service Program.
3. Mail this completed form along with the original prescription and copayment to: Blue Cross of California Mail Service Program, P. O. Box 961025, Fort Worth, TX 76161-9863.
4. Be sure to write your identification number (on your ID card) on the back of each prescription.
5. Drugs will be delivered postage-paid directly to your home. If you have any questions or problems concerning your prescription order, or if you do not receive your medication in 14 days, please contact the Blue Cross of California Mail Service Program toll-free at 1-866-274-6825. Allow a few extra days for first submissions.

HOW DO I ORDER REFILLS OR NEW PRESCRIPTIONS?

- For **refills**, complete the Prescription Order Form provided with your order and **mail** or **FAX** it to the Blue Cross of California Mail Service Program. You may also **call** PrecisionRx toll free at 1-866-274-6825. Be ready to provide your prescription number(s) and credit card information.
- The prescription label and the Customer Receipt will indicate the number of times you may have a prescription refilled.
- PrecisionRx is pleased to announce a convenient new way to order refills. You can do this by visiting the member area of our website at: www.precisionrx-online.com
- For **new prescriptions**, simply complete the Prescription Order Form included with each order and **mail** both the form and original prescription(s) to: Blue Cross of California Mail Service Program, P. O. Box 961025, Fort Worth, TX 76161-9863. Be sure to write your identification number on the back of each prescription.

FOR MORE INFORMATION CONTACT A BLUE CROSS OF CALIFORNIA REPRESENTATIVE AT:

1-866-274-6825

TDD-Hearing Impaired: 1-800-905-9821

Hours: 9:00 a.m. to 10:00 p.m. EST, Mon.-Fri.

9:00 a.m. to 8:00 p.m. EST, Sat

Closed Sunday

DETACH HERE

CONFIDENTIAL PATIENT PROFILE

DETACH HERE

Have you ever used the Blue Cross of California Mail Service Prescription Program? [] Yes [] No

Please complete the section below for all eligible family members. This information will be used to check for potential drug interactions when you have prescriptions filled through PrecisionRx.

INCLUDE LAST NAMES
IF NOT THE SAME AS
SUBSCRIBER

	ALLERGIES					HEALTH CONDITIONS					
	None	Penicillin (1)	Chocolate (2)	Suffa (3)	Aspirin (4)	Thyroid (5)	Diabetes (6)	Glaucoma (7)	Heart Conditions (8)	High Blood Pressure (9)	Other
Subscriber Name											
Spouse											
Child											
Child											
Child											

If additional space is needed, please list other allergies or health conditions.

PLEASE READ AND SIGN:

I certify that the information provided on this form is correct and authorize the release of all information to the plan sponsor, administrator or underwriter; and I AUTHORIZE BLUE CROSS OF CALIFORNIA MAIL SERVICE PROGRAM TO SUBSTITUTE GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE, IN ACCORDANCE WITH APPLICABLE LAW, CONSISTENT WITH MY DOCTOR'S ORDERS.

(Signature)

(Date Signed)