



**C Tell us about the people getting prescriptions.** If there are more than two people, please complete another form.

**1st person** with a refill or new prescription. This person needs:  Easy open caps  Spanish forms and labels

LAST NAME [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] FIRST NAME [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] M Suffix (JR,SR) [ ] [ ] [ ]

NICKNAME [ ] [ ] Gender:  M  F Date of Birth: MM-DD-YYYY

Your E-Mail: \_\_\_\_\_ Date new prescription written: \_\_\_\_\_

Doctor's Last Name \_\_\_\_\_ Doctor's First Name \_\_\_\_\_ Doctor's Phone # \_\_\_\_\_

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

Allergies:  None  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfa  Other: \_\_\_\_\_

Health Information:  Arthritis  Asthma  Diabetes  Acid Reflux  Glaucoma  Heart Problem  High Blood Pressure  High Cholesterol  Migraine  Osteoporosis  Prostate Issues  Thyroid  Other: \_\_\_\_\_

**2nd person** with a refill or new prescription. This person needs:  Easy open caps  Spanish forms and labels

LAST NAME [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] FIRST NAME [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] M Suffix (JR,SR) [ ] [ ] [ ]

NICKNAME [ ] [ ] Gender:  M  F Date of Birth: MM-DD-YYYY

Your E-Mail: \_\_\_\_\_ Date new prescription written: \_\_\_\_\_

Doctor's Last Name \_\_\_\_\_ Doctor's First Name \_\_\_\_\_ Doctor's Phone # \_\_\_\_\_

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

Allergies:  None  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfa  Other: \_\_\_\_\_

Health Information:  Arthritis  Asthma  Diabetes  Acid Reflux  Glaucoma  Heart Problem  High Blood Pressure  High Cholesterol  Migraine  Osteoporosis  Prostate Issues  Thyroid  Other: \_\_\_\_\_

**D Special Instructions:** \_\_\_\_\_

**E How would you like to pay for this order?** Fill in the oval to choose a payment.

- Electronic Check.** Pay from your bank account. First time users register online or call Customer Care.
- Bill Me Later®.** Works like a credit card. First time users register online or call Customer Care.
- Credit or Debit Card.** (VISA®, MasterCard®, Discover®, or American Express®)
  - Fill in this oval to use your card on file.
  - Fill in this oval to use a new card or to update your card expiration date.

CARD NUMBER [ ] Exp. Date MMY Y

**Check or Money Order.** Amount: \$ [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

• Make check or money order out to CVS Caremark.  
• Write your prescription benefit ID number on your check or money order.  
• If your check is returned, we will charge you up to \$40.  
**Payment for Balance Due and Future Orders:** If you chose Electronic Check, Bill Me Later®, or a Credit or Debit Card, we will also use it to pay for any balance that you owe and for future orders.

Fill in this oval if you **DO NOT** want to use this payment method for future orders.

Credit Card Holder Signature/Date \_\_\_\_\_

**Regular delivery is free** and will take 7 to 10 days from the day you send this form.  
**If you want faster delivery, choose:**

- 2nd Business Day (\$17)** Business days are only Monday-Friday
- Next Business Day (\$23)** Monday-Friday

- Faster delivery charges may change.
- Faster delivery is for shipping time, not processing time.
- Faster delivery can only be sent to a street address, not a PO box.



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