

Mail this form to:

Johns Hopkins Advantage MD  
 c/o CVS Caremark  
 PO Box 2110  
 Pittsburgh, PA 15230-2110

Enter ID # below if not shown or if different from above

Prescription Plan Sponsor or Company Name

Please use **blue or black ink, capital letters**, and fill in **both sides** of this form.

**New Prescriptions** - Mail your new prescriptions with this form.

Number of **New** prescriptions:

**Refills** - Order by Web, phone, or write in Rx number(s) below.

Number of **Refill** prescriptions:

**A Shipping Address.** To ship to an address different from the one printed above, please make changes here.

Last Name	First Name	MI	Suffix (JR, SR)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street Name	Apt./Suite #	<input type="radio"/> Use this address for this order only.	
<input type="text"/>	<input type="text"/>		
City	State	ZIP Code	
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/>	
Daytime Phone #:	Evening Phone #:		
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>		

**B Refills.** To order mail service refills, enter your prescription number(s) here.

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_  
 5) \_\_\_\_\_ 6) \_\_\_\_\_ 7) \_\_\_\_\_ 8) \_\_\_\_\_

We may package all of these prescriptions together unless you tell us not to.



Please fold here →

Please fold here →

Please fold here →

Please fold here →

**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 MMYY

**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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