PATIENT MAIL ORDER FORM

PLEASE COMPLETE ALL PORTIONS OF THIS FORM BY PRINTING IN **ALL CAPITAL LETTERS** USING **BLACK INK.**
IF THERE ARE MORE THAN 3 FAMILY MEMBERS, WRITE THE INFORMATION ON A SEPARATE PIECE OF PAPER.

CARDHOLDER ID NUMBER
(REFER TO YOUR PLAN ID CARD)
CARDHOLDER FIRST NAME M.I. CARDHOLDER LAST NAME

DRUG ALLERGIES: (CHECK ALL THAT APPLY) PENICILLIN (01) ASPIRIN (03) CODEINE (04) SULFA (15)
TETRACYCLINE (07) ERYTHROMYCIN (09) OTHER:
NO KNOWN DRUG ALLERGIES (00) BIRTH DATE – – GENDER

PLEASE PROVIDE A STREET ADDRESS. CERTAIN MEDICATIONS CANNOT BE DELIVERED TO A POST OFFICE BOX.

MAILING ADDRESS

CITY

STATE ZIP CODE –

PHONE # – –

PHYSICIAN LAST NAME PHYSICIAN PHONE # – –

FAMILY MEMBER 1 FIRST NAME M.I. FAMILY MEMBER 1 LAST NAME

DRUG ALLERGIES: (CHECK ALL THAT APPLY) PENICILLIN (01) ASPIRIN (03) CODEINE (04) SULFA (15)
TETRACYCLINE (07) ERYTHROMYCIN (09) OTHER:
NO KNOWN DRUG ALLERGIES (00) BIRTH DATE – – GENDER
PHYSICIAN LAST NAME PHYSICIAN PHONE # – –

FAMILY MEMBER 2 FIRST NAME M.I. FAMILY MEMBER 2 LAST NAME

DRUG ALLERGIES: (CHECK ALL THAT APPLY) PENICILLIN (01) ASPIRIN (03) CODEINE (04) SULFA (15)
TETRACYCLINE (07) ERYTHROMYCIN (09) OTHER:
NO KNOWN DRUG ALLERGIES (00) BIRTH DATE – – GENDER
PHYSICIAN LAST NAME PHYSICIAN PHONE # – –

Please note that all prescriptions requiring a formulary exception will not be processed without prior approval. To prevent any delays, make sure that an approved formulary exception (if applicable) is on file before you place your order.

Thank you for using our Mail Service Prescription Drug Program.

MAS/

BlueCross BlueShield of Massachusetts

BUSINESS REPLY MAIL

1 OZ. LETTER RATE PERMIT NO. 589 BENSALEM, PA

EXPRESS SCRIPTS
PO BOX 1086
BENSALEM, PA 19020-9380

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

FAMILY MEMBER 3 FIRST NAME M.I. FAMILY MEMBER 3 LAST NAME

DRUG ALLERGIES: (CHECK ALL THAT APPLY) PENICILLIN (01) ASPIRIN (03) CODEINE (04) SULFA (15)
TETRACYCLINE (07) ERYTHROMYCIN (09) OTHER:

NO KNOWN DRUG ALLERGIES (00) BIRTH DATE – – GENDER

PHYSICIAN LAST NAME PHYSICIAN PHONE # – –

2. PAYMENT METHOD

PLEASE INCLUDE PAYMENT WITH YOUR ORDER. **DO NOT SEND CASH.** STANDARD DELIVERY OF YOUR ORDER IS **FREE** AND WILL ARRIVE WITHIN 14 DAYS FROM THE DATE WE RECEIVE YOUR ORDER.

MAS/MDX

NOTE: YOUR CREDIT CARD WILL BE CHARGED ACCORDING TO YOUR PRESCRIPTION PLAN. ALL FUTURE ORDERS WILL BE CHARGED TO THIS CREDIT CARD, UNLESS PAYMENT (CHECK) ACCOMPANIES THE ORDER.

CREDIT CARD # EXPIRATION DATE –

CARDHOLDER NAME
PLEASE PRINT NAME AS IT APPEARS ON CREDIT CARD

NOTE: IF PAYING BY CHECK OR MONEY ORDER, PLEASE REFER TO YOUR PRESCRIPTION PLAN MATERIALS FOR COPAY.

CHECK/MONEY ORDER AMOUNT ENCLOSED $.

3. SIGNATURE REQUIRED

PLEASE CHECK ANY OF THE TWO OPTIONS (IF APPLICABLE) AND SIGN THE FOLLOWING STATEMENT.

I WOULD LIKE MY PRESCRIPTIONS DISPENSED WITH NON-CHILD RESISTANT (EASY OPEN) CAPS.

I REQUEST THAT THIS AND FUTURE ORDERS BE SHIPPED "SIGNATURE REQUIRED" FOR AN ADDITIONAL CHARGE.

I CERTIFY THAT ALL THE INFORMATION ON THIS FORM IS CORRECT, INCLUDING ANY SELECTIONS MADE FOR SENDING MY ORDER "SIGNATURE REQUIRED" OR FOR NON-CHILD RESISTANT (EASY OPEN) CAPS. I PERMIT EXPRESS SCRIPTS INC. TO RELEASE ALL INFORMATION ON THIS FORM CONCERNING PRESCRIPTION ORDERS TO MY PLAN SPONSOR, ADMINISTRATOR OR HEALTH PLAN FOR THE PURPOSE OF PAYMENT, TREATMENT, OR HEALTH CARE OPERATIONS.

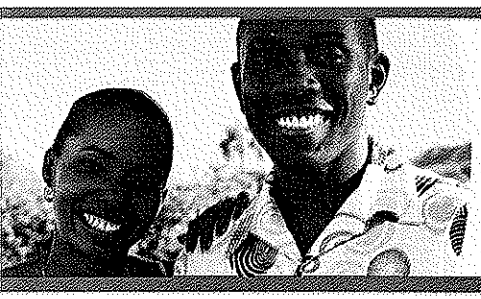
4. REVIEW YOUR PRESCRIPTION

TO AVOID DELAYS IN PROCESSING YOUR ORDER:

- **CHECK TO SEE IF THE PATIENT NAME, ADDRESS AND DATE OF BIRTH IS CLEARLY WRITTEN ON THE PRESCRIPTION.** IF NOT, PRINT THE PATIENT'S FULL NAME, ADDRESS, PHONE NUMBER AND DATE OF BIRTH ON THE BACK OF THE PRESCRIPTION.
- **CHECK TO SEE IF THE PHYSICIAN SIGNATURE IS LEGIBLE AND PHYSICIAN PHONE NUMBER IS PRINTED ON THE PRESCRIPTION.** IF NOT, PLEASE CIRCLE THE PHYSICIAN'S NAME ON THE PRESCRIPTION, OR PRINT THE PHYSICIAN NAME AND PHONE NUMBER, INCLUDING AREA CODE ON THE BACK OF THE PRESCRIPTION.

NOTE: WE WILL DISPENSE FDA APPROVED GENERIC MEDICATIONS WHEN ALLOWED BY YOUR PHYSICIAN, SUBJECT TO THE TERMS OUTLINED IN YOUR PLAN.

QUESTIONS ABOUT YOUR PHARMACY BENEFIT?
CALL THE CUSTOMER SERVICE NUMBER LOCATED ON YOUR ID CARD.



As a member of Blue Cross Blue Shield of Massachusetts, you can use your Mail Service Prescription Drug Program to buy certain medications. It's a great way to save by purchasing prescriptions on a long-term basis.

Check These Benefits!

Savings The biggest advantage of the Mail Service Prescription Drug Program is that for most long-term maintenance medications you can order up to a 90-day supply through the mail. Often times, using mail service results in the lowest possible out-of-pocket costs to you as a member.

Convenience You can receive your medications through the mail, at home, postage paid, within 14 days of mailing your prescription.

Confidentiality If you have questions, you can call Express Scripts® toll free, 24 hours a day. Registered pharmacists are available to answer your questions about your mail order confidentially. Call **1-800-892-5119**.

Special-Needs Services Available by Mail. For the convenience of our hearing-impaired members, Express Scripts has TDD equipment, and has installed a separate toll-free number for you to use with your equipment. The number is **1-800-305-5376**.

For our vision-impaired members, upon special request with your order, Express Scripts can provide Braille labels for your medication.

And for our non-English-speaking members, Express Scripts can provide translation services when you call the toll-free line.

Refer to your benefit literature for specific coverage information.

Three Easy Steps To Use Mail Service

For long-term prescriptions, use our Mail Service Prescription Drug Program to save.

1. Ask your doctor to prescribe medications for up to a 90-day supply, plus refills when applicable. (If you're already taking medication on a long-term basis, ask your doctor for a new prescription.)
2. Complete the attached Mail Order Form(s) for each member submitting a prescription. Be sure to answer all of the questions.
3. Seal the form(s), prescriptions, and the appropriate copayment in the pocket in this brochure (do not send cash). Then just mail it in. Be sure to write your ID number exactly as it appears on your identification card.

Your order will be quickly processed and sent to you by mail or UPS. Allow 14 days for delivery from the date you mailed the order. To prevent delays, do not fill medications that are needed quickly or short-term medications (e.g. antibiotics) via mail order.

Confidential Subscriber/Patient Profile

Please write your ID number, name, and address on the attached form. Then complete the Patient Profile for you and each of your dependents submitting prescriptions, indicating any drug allergies, and health conditions. Express Scripts will use this information to check any potential drug interactions when you have prescriptions filled. If there are no drug allergies, please check "None" in the box provided.

Instructions

New Prescriptions:

- Have your doctor/provider write the prescription for up to a 90-day supply
- To prevent any delays, make sure that an approved formulary exception (if applicable) for any medications that are non-covered or require prior authorization is on file before you place your order
- Complete all information requested on the attached Mail Order Form
- Select your preference for Safety Caps in the appropriate box
- Ensure that patients' full name, age, ID #, and address appear on each prescription
- Find out the appropriate copayment necessary for the medication prescribed
- Place prescription(s) and copayment(s) in return envelope and mail

Refills:

- Call **1-800-892-5119** or visit **www.express-scripts.com** to refill your order or
- Place refill slip(s) and copayment(s) in return envelope and mail

Make all checks or money orders payable to Express Scripts. Do not send cash. If paying by credit card, complete the information under "Credit Card Information."

PLEASE PRINT CLEARLY

Answers To Your Questions

How Do I Determine What Copayment Amount I Should Include With My Order?

Check your benefit literature, and if you still have specific questions, call the Blue Cross Blue Shield of Massachusetts Member Service phone number listed on your ID card.

Why Did My Order Contain Generic Drugs When My Prescription Requested A Brand-Name Version?

When authorized by your doctor and permitted by applicable law, Express Scripts will dispense a generic drug. This usually saves you money, so whenever possible, ask your doctor to prescribe generic drugs.

Why Is My Drug Not Available Through The ESI Mail Service?

Certain medications that require immediate administration and/or are used for short periods of time are inappropriate for mail service. In addition, for certain medications classified as specialty drugs, Blue Cross Blue Shield of Massachusetts has established a relationship with a preferred specialty pharmacy. They offer additional added-value services that are not offered by our mail service pharmacy.

How Do I Order Refills?

Simply call the toll-free number **1-800-892-5119** and order your refills over the phone. You can also visit the Express Scripts website to refill your order (**www.express-scripts.com**). Also, once you have ordered through mail service, you will receive a refill slip with your prescription.

Enclose the slip and the appropriate copayment amount in the order envelope (which is provided).

What Do I Do In Emergency Situations?

When you need medication immediately, simply have your prescription filled at a local pharmacy. If you need medication immediately, but will be taking it on an ongoing basis, you can ask your doctor to write two prescriptions:

- You can fill the first prescription at a local participating pharmacy;
- Send the second prescription (up to a 90-day supply), along with your copayment, to Express Scripts immediately.

About Your Prescription

Blue Cross Blue Shield of Massachusetts maintains a list of covered prescription drugs. If you have any questions about whether or not your medications are covered, or subject to Quality Care Dosing, step therapy, or prior authorization, please visit **www.bluecrossma.com** and proceed to **Pharmacy Program** or call the Blue Cross Blue Shield Member Service telephone number on your ID card.

Mail Service Questions

Call Express Scripts Customer Service
24 Hours A Day, 7 Days A Week
(Best times to call are Tuesday through Friday afternoons)

Emergency mail service pharmacy consultation is also available around-the-clock.

Toll-Free Number: 1-800-892-5119

(TDD: **1-800-305-5376**)

Please Note: Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations and to the professional judgment of the pharmacist. If you have any questions regarding your medication, please call Express Scripts customer service at 1-800-892-5119.

It's the patient's responsibility to report to Express Scripts changes in drug allergies, health conditions, chronic diseases, and drug sensitivities.

Prescription information about members and dependents is used by Express Scripts to administer your prescription program. As part of the administration, Express Scripts reports that information to Blue Cross Blue Shield of Massachusetts. Express Scripts also uses the information and prescription data gathered from claims submitted nationwide for reporting and analysis, without identifying individual patients in accordance with applicable laws.

BlueCross BlueShield of Massachusetts

Express Scripts®

YOUR MAIL SERVICE PRESCRIPTION PROGRAM

BlueCross BlueShield of Massachusetts

An Independent Licensee of the Blue Cross and Blue Shield Association