



**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.

Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender:  M  F

Date of Birth: MM-DD-YYYY

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

Doctor's Last Name

Doctor's First Name

Doctor's Phone #

Tell us about new health information for 1st person if never provided or if changed.

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

Medical Conditions:  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.

Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender:  M  F

Date of Birth: MM-DD-YYYY

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

Doctor's Last Name

Doctor's First Name

Doctor's Phone #

Tell us about new health information for 2nd person if never provided or if changed.

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

Medical Conditions:  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?** (If your copay is \$0, you do not need to provide payment information.)

- Electronic Check.** Pay from your bank account. (You must first register online or call Customer Care.)
- Use my PayPal Credit account.** Works like a credit card. (You must first 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, PayPal Credit, 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 us to use this payment method for future orders.

Credit Card Holder Signature/Date

**Regular delivery is free** and will take up 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 only, not processing.
- Faster delivery can only be sent to a street address, not a PO Box.



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