



MASSACHUSETTS

# Your Mail Service

## Pharmacy Benefit



As a member of Blue Cross Blue Shield of Massachusetts, you can buy certain medications at the Express Scripts mail service pharmacy.

It's a great way to save by purchasing prescriptions on a long-term basis.

### Check Out These Benefits!

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

**Convenience:** Your medications will be delivered to your home, postage paid, within 14 days of mailing your new 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 prescriptions confidentially. Call 1-800-892-5119.

**Special-Needs Services Available:** For the convenience of our hearing-impaired members, Express Scripts is TTY-ready, and has installed a separate toll-free number for you to use with your TTY 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 pharmacy 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 for each member submitting a prescription. Be sure to answer all of the questions.
3. Seal the form, prescriptions, and the appropriate copayment in the pocket in this brochure (do not send cash). Then simply mail it in. Be sure to write your ID number exactly as it appears on your ID card.

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

### 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 the patient's full name, age, ID number, and address appear on each prescription
- Find out the appropriate copayment necessary for the medication prescribed
- Place prescriptions and copayments in return envelope and mail

### Refills:

- Call 1-800-892-5119 or visit [www.express-scripts.com](http://www.express-scripts.com) to refill your order, or
- Place refill slips and copayments in the return envelope and mail it

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."

## 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/pharmacy](http://www.bluecrossma.com/pharmacy) or call Blue Cross Blue Shield of Massachusetts Member Service at the number on the front of your ID card.

## Mail Service Questions

Call Express Scripts customer service 24 hours a day, 7 days a week. Pharmacy consultation is also available around-the-clock. **Toll-free number: 1-800-892-5119 (TTY: 1-800-305-5376)**

## 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 the front of 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 Isn't My Drug Available Through the ESI Mail Service?

Certain medications that require immediate administration 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 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](http://www.express-scripts.com)). 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).

#### 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 any 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.



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32-7040  
147610M

**Mail Service Order Form**

		<b>Mail this form to:</b>	
		 CVS Caremark PO BOX 659541 SAN ANTONIO, TX 78265-9541	
Member ID # (if not shown or if different from above) <input type="text"/>			
Prescription Plan Sponsor or Company Name			
<b>Instructions:</b> Please use <b>blue or black ink</b> and <b>print in capital letters</b> . Fill in <b>both sides</b> of this form.			
<b>New Prescriptions</b> - Mail your new prescriptions with this form.		Number of <b>New</b> prescriptions: <input type="text"/> <input type="text"/>	
<b>Refills</b> - Order by Web, phone, or write in Rx number(s) below.		Number of <b>Refill</b> prescriptions: <input type="text"/> <input type="text"/>	
<b>TO RECEIVE YOUR ORDER SOONER</b> request refills or new prescriptions online at <a href="http://www.caremark.com">www.caremark.com</a> or call the toll-free number on your member ID card.			
<b>A Shipping Address.</b> To ship to an address different from the one printed above, enter the changes here.			
Last Name <input type="text"/>	First Name <input type="text"/>	MI      Suffix (JR, SR) <input type="checkbox"/> <input type="text"/>	
Street Address <input type="text"/>	Apt./Suite # <input type="text"/>	<input type="checkbox"/> <b>Use shipping address for this order only.</b>	
City <input type="text"/>	State <input type="text"/>	ZIP Code <input type="text"/> - <input type="text"/>	
Daytime Phone #: <input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/>	Evening Phone #: <input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/>		
<b>B Refills.</b> To order mail service refills, enter your prescription number(s) here.			
1) <input type="text"/>	2) <input type="text"/>	3) <input type="text"/>	4) <input type="text"/>
5) <input type="text"/>	6) <input type="text"/>	7) <input type="text"/>	8) <input type="text"/>
CVS Caremark wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Special Instructions" section of this form.			

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

All claims for prescriptions submitted to CVS Caremark Mail Service Pharmacy using this form will be submitted to your prescription benefit plan for payment. If you do not want them submitted to your plan, do not use this form. You may call Customer Care to make alternate arrangements for submission of your order and payment.



Please fold here ↑

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\* WEB

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\* WEB

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

**First person** with a refill or new prescription.

Last Name

Nickname

First Name

Spanish forms and labels

MI

Suffix  
(JR,SR)

Gender:  M  F

Date of birth:  -  -

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: \_\_\_\_\_

**Second person** with a refill or new prescription.

Last Name

Nickname

First Name

Spanish forms and labels

MI

Suffix  
(JR,SR)

Gender:  M  F

Date of birth:  -  -

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.)

**Credit or debit card.** (VISA®, MasterCard®, Discover®, or American Express®)

Use your card on file.

Use a new card or update your card's expiration date.

Exp. Date     MMYY

**Check or money order.** Amount: \$    .

• Make check or money order payable 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 choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

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

MOF WEB 0316 SAT

Credit card holder signature/Date

**Regular delivery is free** and takes up to 5 days after your order is processed.

**If you want faster delivery, choose:**

**2nd business day (\$17)**

**Next business day (\$23)**

Faster delivery  
can only be  
sent to a  
street address,  
not a PO Box

**Expected processing time from receipt of this form:**

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor  
(Charges subject to change)

