



**Mail Service Pharmacy Order Form**

CVS Caremark Mail Service Pharmacy  
PO BOX 2110  
PITTSBURGH, PA 15230-2110

[illegible]

**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.

☐ Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

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:

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

☐ Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

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.)

☐ **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.

CARD NUMBER Exp. Date MMYY

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

Credit card holder signature/Date

- 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.

**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)**

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

☐ **Next business day (\$23)**

**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)

