



Prescription Savings


 CAREMARK SAT STD
 PO BOX 659541
 SAN ANTONIO, TX 78265-9541

[illegible]

A	A	A			
---	---	---	--	--	--

Address Change/Shipping Information (Complete **ONLY IF DIFFERENT** or not shown above)

[illegible][illegible]

--	--	--	--

[illegible]

--	--	--	--

**Use this address
for this order only.**

[illegible]

--	--

$$\begin{array}{|c|c|c|c|c|} \hline & & & & \\ \hline \end{array} - \begin{array}{|c|c|c|c|} \hline & & & \\ \hline \end{array}$$

Daytime Phone#: - -

Evening Phone#: - -

NEW prescriptions - Mail Rx(s) with this form. REFILLS - Put refill sticker(s) below.

If space is needed for more refill labels, you may: 1) attach labels to a blank piece of paper and send with this order form, or 2) print a Refill Order Continuation Form at our Web site above, or 3) call Caremark Customer Care at the toll-free number above.

Apply Caremark Refill Label here

--	--	--	--	--	--	--	--	--

or

write prescription number above

Apply Caremark Refill Label here

--	--	--	--	--	--	--	--	--

or

write prescription number above

Apply Caremark Refill Label here

--	--	--	--	--	--	--	--	--

or

write prescription number above

Apply Caremark Refill Label here

--	--	--	--	--	--	--	--	--

or

write prescription number above

Unless otherwise directed, all prescriptions received on a single order form or in a single envelope may be shipped together in one package.

Please turn over to provide additional information.

©2008 Caremark. All rights reserved.



Fill in for up to two individuals who will receive prescriptions with this order.

#1: ☐ Easy open caps ☐ Print materials in Spanish
Last Name First Name MI Suffix (JR, SR)
Alternate Name (Nickname) Gender: ☐ M ☐ F Date of Birth: - -
E-mail Address: Date new prescription(s) received from doctor:

Doctor / Prescriber's Last Name Doctor / Prescriber's First Name Doctor / Prescriber's Telephone # - -

COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

Allergies: ☐ Aspirin ☐ Cephalosporin ☐ Codeine ☐ Erythromycin ☐ Peanuts ☐ Penicillin ☐ Sulfonamides/Sulfa
☐ None ☐ Other:

Health Conditions: ☐ Arthritis ☐ Asthma ☐ Diabetes ☐ GERD (Acid Reflux) ☐ Glaucoma ☐ Heart Condition
☐ High Blood Pressure ☐ High Cholesterol ☐ Migraine ☐ Osteoporosis ☐ Prostate Disorders ☐ Thyroid
☐ Other:

#2: ☐ Easy open caps ☐ Print materials in Spanish
Last Name First Name MI Suffix (JR, SR)
Alternate Name (Nickname) Gender: ☐ M ☐ F Date of Birth: - -
E-mail Address: Date new prescription(s) received from doctor:

Doctor / Prescriber's Last Name Doctor / Prescriber's First Name Doctor / Prescriber's Telephone # - -

COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

Allergies: ☐ Aspirin ☐ Cephalosporin ☐ Codeine ☐ Erythromycin ☐ Peanuts ☐ Penicillin ☐ Sulfonamides/Sulfa
☐ None ☐ Other:

Health Conditions: ☐ Arthritis ☐ Asthma ☐ Diabetes ☐ GERD (Acid Reflux) ☐ Glaucoma ☐ Heart Condition
☐ High Blood Pressure ☐ High Cholesterol ☐ Migraine ☐ Osteoporosis ☐ Prostate Disorders ☐ Thyroid
☐ Other:

Comments/Special Instructions:

Method of Payment/Shipping Information

Please make check or money order payable to **Caremark**. Include ID# on check/money order.

☐ Check ☐ Money Order/Cashier's Check ☐ Voucher/Coupon Amt. of check/money order: \$.

(Checks returned for insufficient funds will be subject to a processing fee of up to \$40, depending on state law.)

OR pay by credit or debit card (preferred). We accept VISA®, MasterCard®, Discover®, and American Express®.

☐ Fill in oval to charge most recently used credit card for this order and future orders for all individuals included in the family.

☐ Fill in oval to charge most recently used credit card for this order only.

To add, change or update your credit card information, write in below:

-
Credit/Debit Card Number Expiration Date

Credit Card Holder Signature Date

Your credit card will be billed for prescription costs and expedited shipping (if requested).

Regular delivery is FREE (allow up to 10 days for delivery).

For faster delivery, mark the appropriate oval below.

Note: Expedited delivery only affects shipping time, not processing time of your order.

Fill in oval for faster delivery:

☐ 2nd Business Day = \$13 (per order) ☐ Next Business Day = \$18 (per order)

(Charges subject to change.)

This is a discount program and not an insurance plan. Discounts are available through Caremark Mail Service Pharmacy.



CRKOF-DISC-0208
106-DOF02
Rev. 05/08
Stock #6403