OPTUMRx®

NEW PRESCRIPTION MAIL-IN ORDER FORM

1 Member and physician information — please use black or blue ink. One form per member.

Member ID Number		(Additional coverage, if applicable) Secondary Member ID Number	
Last Name		First Name	MI
Delivery Address			Apt. #
City	State	ZIP	Phone Number with Area Code
Date of Birth (mm/dd/yyyy)	Gender O M O F	Email	
Physician Name		Physician Phone Number with Area Code	

2 Health history

Medication Allergies:	O Aspirin	O Erythromycin	O Quinolones	O Others: _____
O None known	O Cephalosporins	O NSAIDs	O Sulfa	_____
O Amoxil/Ampicillin	O Codeine	O Penicillin	O Tetracyclines	_____
Health Conditions:	O Asthma	O Glaucoma	O High cholesterol	O Others: _____
O None known	O Cancer	O Heart condition	O Osteoporosis	_____
O Arthritis	O Diabetes	O High blood pressure	O Thyroid Disease	_____

Over-the-counter/herbal medications taken regularly:

3 Pharmacy processing

Generic substitution. FDA-approved generic equivalents will be dispensed for brand-name drugs whenever possible, unless you or your physician indicate otherwise. Brand-name medications may be subject to a higher cost. **If you require brand-name medications, please list those medications here:**

Keep on file. If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them here:

Notes to pharmacy:

4 Payment and shipping information — do not send cash

Standard delivery is included at no charge. New prescriptions should arrive within about 10 business days from the date the completed order is received. Completed refill orders should arrive within about 7 business days. OptumRx will contact you if there will be an extended delay in delivering your medications.

You may log on to **www.optumrx.com** to see if drug pricing information is available before enclosing payment. Once shipped, medications may not be returned for a refund or adjustment.

O **Ship overnight.** Add $12.50 to order amount (subject to change).

O **Check enclosed.** All checks must be signed and made payable to: OptumRx.

O **Charge to my credit card on file.**

O **Charge to my NEW credit card.**

New Credit Card Number

Expiration Date (Month/Year) ___/___

Visa, MasterCard, AMEX and Discover are accepted.

Signature: _____ **Date:** _____

For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance and other such expenses related to prescription orders. By supplying my credit card number, **I authorize OptumRx to maintain my credit card on file as payment method for any future charges.** To modify payment selection, contact customer service at any time.

5 Mail this completed order form with your new prescription(s) to OptumRx, P.O. Box 2975, Mission, KS 66201. DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.

OPTUMRx®

NEW PRESCRIPTION PHYSICIAN FAX ORDER FORM

Use this form to order a new mail service prescription by fax from the prescribing physician's office. Member completes section 1, while the physician completes sections 2 and 3. **This fax is void unless received directly from physician's office. To contact OptumRx, physicians may call 1-800-791-7658.**

1 Member information — to be completed by member

Member ID Number		(Additional coverage, if applicable) Secondary Member ID Number	
Last Name		First Name	MI
Delivery Address			Apt. #
City	State	ZIP	Phone Number with Area Code
Date of Birth (mm/dd/yyyy)	Gender O M O F	Email	

Medication Allergies:
O None known
O Amoxil/Ampicillin
O Aspirin
O Cephalosporins
O Codeine
O Erythromycin
O NSAIDs
O Penicillin
O Quinolones
O Sulfa
O Tetracyclines
O Others:

Health Conditions:
O None known
O Arthritis
O Asthma
O Cancer
O Diabetes
O Glaucoma
O Heart condition
O High blood pressure
O High cholesterol
O Osteoporosis
O Thyroid Disease
O Others:

Over-the-counter/herbal medications taken regularly:

Keep on file. If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them here:

Notes to pharmacy:

2 Physician and prescription information — physician to complete this section

Prescribing Physician Name		Patient Name	DOB
Physician Phone Number with Area Code		Rx *Enter prescription details here or attach your office prescription to the form.*	
Physician Fax Number with Area Code			
Physician Street Address			
City, State, ZIP			
NPI	DEA		

This document and others if attached contain information from OptumRx that is privileged, confidential and/or may contain protected health information (PHI). We are required to safeguard PHI by applicable law. The information in this document is for the sole use of the person(s) or company named above. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately and return the document(s) by mail to OptumRx Privacy Office, 17900 Von Karman, M/S CA016-0101, Irvine, CA 92614.

Refills: O 1 O 2 O 3 O Other: _____

Dispense as written: O Yes

X_____ _____
Physician Signature Date

3 Physician to fax completed order form to OptumRx at 1-800-491-7997.