

SAVE MONEY ON YOUR MEDICATIONS WITH THE MAIL SERVICE PHARMACY

Maintenance medications, also known as long-term medications, are used to treat chronic or ongoing conditions. Save 33% when you order them in 90-day supplies through the mail service pharmacy.¹



BENEFITS OF USING THE MAIL SERVICE PHARMACY



You'll pay 33% less for 90-day supplies of most maintenance medications (that's one less copay).



There's no additional cost for standard delivery.



Signing up for automatic refills makes it less likely to miss a dose.

EXAMPLE OF HOW YOU'LL SAVE²

TYPE OF PRESCRIPTION	MEDICATION COPAY		
	Tier 1	Tier 2	Tier 3
30-day supply, retail pharmacy	\$15	\$30	\$50
90-day supply, mail service pharmacy	\$30	\$60	\$150

1. In most cases for eligible maintenance medications. Check plan materials for more details.

2. For illustrative purposes only, using a 3-tier plan.

HOW TO USE THE MAIL SERVICE PHARMACY

Download the MyBlue app or create an account at bluecrossma.org. Once signed in, click **Pharmacy Benefit Manager** under **My Medications**, then go to the **Prescriptions** tab. To:

TRANSFER PRESCRIPTIONS

Click
Start Rx Delivery by Mail

ORDER REFILLS

Click
View/Refill All Prescriptions

SET UP AUTOMATIC REFILLS

Click
Manage Automatic Refills

You can also fill prescriptions by calling CVS Customer Care at **1-877-817-0477** (TTY: 711), or by using the included order form.

WHY ISN'T MY MEDICATION AVAILABLE THROUGH THE MAIL SERVICE PHARMACY?

Certain medications that require immediate administration or are used for short periods of time aren't available through the mail service pharmacy. In addition, some specialty medications are only available through specialty pharmacies.

Please Note:

Certain prescribed medications may be subject to other dispensing limitations and to the professional judgment of the pharmacist. If you have any questions about your medication, call CVS Customer Care at **1-877-817-0477** (TTY: 711).

It's the patient's responsibility to report any changes in drug allergies, health conditions, chronic diseases, and drug sensitivities.

Prescription information about members and dependents is used to administer your prescription program. That information is reported to Blue Cross Blue Shield of Massachusetts, and is used for reporting and analysis, without identifying individual patients in accordance with applicable laws.

Questions?

If you have any questions, call CVS Customer Care at **1-877-817-0477** (TTY: 711).



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

CaremarkPCS Health, LLC ("CVS Caremark") is an independent company that has been contracted to administer pharmacy benefits and provide certain pharmacy services for Blue Cross Blue Shield of Massachusetts. CVS Caremark is part of the CVS Health family of companies. Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association. * Registered Marks of the Blue Cross and Blue Shield Association. © 2022 Blue Cross and Blue Shield of Massachusetts, Inc., or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

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Mail Service Order Form

Please fold here →

Abstract

CVS Caremark
PO BOX 659541
SAN ANTONIO, TX 78265-9541

Member ID # (if not shown or if different from above)

[illegible]

Prescription Plan Sponsor or Company Name

Please use **blue or black ink** and **print in capital letters**. Fill in **both sides** of this form.

New Prescriptions - Mail your new prescriptions with this form.

Number of **New** prescriptions:

Refills - Order by Web, phone, or write in Rx number(s) below.

Number of **Refill** prescriptions:

TO RECEIVE YOUR ORDER SOONER request refills or new prescriptions online at **bluecrossma.org**.

Go to **90-Day Mail Service** under **My Medications**.

A Shipping Address. To ship to an address different from the one printed above, enter the changes here.

Last Name												First Name					MI	Suffix (JR, SR)			
Street Address												Apt./Suite #					☐ Use shipping address for this order only.				
City												State			ZIP Code						
Daytime Phone #:												Evening Phone #:									

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

B Refills. To order mail service refills, enter your prescription number(s) here.

1) _____ 2) _____ 3) _____ 4) _____
5) _____ 6) _____ 7) _____ 8) _____

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.

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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 →

please fold here →

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.

☐ Spanish forms and labels

Last Name

Nickname

First Name

MI

Suffix (JR,SR)

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

Nickname

First Name

MI

Suffix (JR,SR)

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.

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.

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)**

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)

