Catamaran Home Delivery
MAIL-ORDER FORM

FOLD HERE

1 Member information: Please verify or provide member information below.

Member ID:

Group:

Name:

Street Address:

Street Address:

City, State, Zip:

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:

☐ New Shipping Address:

Catamaran Home Delivery will keep this address on file for all orders from membership until another shipping address is provided by any person in this membership.

*A physical address (not a P.O. Box) is typically required for temprature-sensitive medications and controlled substances.

Daytime phone:

Evening phone:

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in the envelope provided.

First name

Last name

Birth date (MM/DD/YYYY)

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

FOLD HERE

3 Complete your order: You can pay by check, money order, or credit card. Make checks and money orders **payable to Catamaran Home Delivery,** and write your member ID number on the front. You can price medications at **www.mycatamaranrx.com**, or call the telephone number listed on your ID card.

Number of prescriptions sent with this order:

Payment options: ☐ Payment enclosed ☐ Credit Card

For credit card payments:

☐ Visa ☐ MC ☐ Discover ☐ Amex

Expiration date

M M Y Y

X

Cardholder signature

Credit card number

☐ I authorize **Catamaran Home Delivery** to charge this card for any person for all orders from in this membership.

Shipping Methods: ☐ Normal (no charge) ☐ 2nd Day Air ($11.00) ☐ Next Day Air ($25.00)

Mailing instructions are provided on the next page.

Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Sex

☐ M ☐ F

Patient's relationship to member

☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex

☐ M ☐ F

Patient's relationship to member

☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

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Important reminders and other information

Check that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective, and less expensive generic drugs.

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using a credit card.

If you are a Medicare Part B beneficiary AND have private health insurance, check your prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at the telephone number listed on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1 800 MEDICARE (1 800 633-4227).

Catamaran Home Delivery will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise.

☐ Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise. **Check the box if you do not wish a less** expensive brand or generic drug.

Please note that this applies only to new prescriptions and to any refills of that prescription.

For additional information or help, visit us at **www.mycatamaranrx.com** or call Member Services at the telephone number listed on your ID card. Member Services is available 24/7. TTY/TDD users should call 1 866 830-3726.

Federal law prohibits the return of dispensed controlled substances.

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Place your prescription(s), this form, and your payment in the envelope provided. Be sure the **Catamaran Home Delivery** address shows through the window. Do not use staples or paper clips.

CATAMARAN HOME DELIVERY
PO BOX 166
AVON LAKE, OH 44012-9927

Commercial Ohio

Health, Allergy & Medication Questionnaire (HMQ)

Your answers to the following questions will help protect you against potentially harmful drug interactions and side effects. We will alert your pharmacist about possible drug allergies and interactions that can be harmful. To best serve you, we need to know if you have any medication allergies or medical conditions. We also need to know what prescription and nonprescription medications you take regularly.

Your privacy is important to us. Catamaran Home Delivery complies with federal privacy regulations and will protect this information.

To complete and return this form, follow the steps below.
Step 1: Verify and complete information in SECTION 1.
Step 2: Complete all sections below using blue or black ink. Please print.
Step 3: In the envelope provided, please return the completed questionnaire, along with your prescription and the mail-order form.

SECTION 1: Patient information

Patient name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
(First name, Last name)

Gender: ☐ Male ☐ Female

Member number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
(Located on your member ID card and/or in your benefit information.)

Date of Birth: ☐ ☐ ☐
Month Day Year

Contact phone: ☐ ☐ ☐

SECTION 2: Your medication allergies

Check the box if you have had an allergy or serious reaction to any of these medications.

- ☐ Aspirin and salicylates (for example: ZORprin®, Trilisate®)
- ☐ Codeine (for example: Tylenol® #3)
- ☐ Erythromycin, Biaxin®, Zithromax®
- ☐ Nonsteroidal anti-inflammatory drugs (NSAIDS) (for example: ibuprofen, Advil®, Motrin®)
- ☐ Penicillins/cephalosporins (for example: Amoxil®, amoxicillin, ampicillin, Keflex®, cephalexin)
- ☐ Sulfa drugs (for example: Septra®, Bactrim®, TMP/SMX)
- ☐ Tetracycline antibiotics

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Patient name: | | | | | | | | | | | | | | | | | | | Date of Birth: | | |

SECTION 3: Your medical conditions

Has your doctor ever told you that you have any of the conditions listed below? If so, check the box next to **all** that apply.

☐ Allergies, hay fever (allergic rhinitis)	☐ Heart failure (CHF)
☐ Arthritis	☐ Hemophilia and hemophilia-like conditions
☐ Asthma	☐ High blood pressure (hypertension)
☐ Bladder control problem (urinary incontinence)	☐ High blood sugar (diabetes)
☐ Brittle bones (osteoporosis)	☐ High cholesterol (hypercholesterolemia)
☐ Chest pain (angina)	☐ Inflammatory bowel disease
☐ Crohn's disease	☐ Migraine headache
☐ Depression	☐ Overactive thyroid (hyperthyroid)
☐ Emphysema (COPD, chronic bronchitis)	☐ Peptic, stomach, or duodenal ulcer
☐ Enlarged prostate (benign prostatic hyperplasia, BPH)	☐ Poor circulation in the legs (peripheral vascular disease)
☐ Gastric reflux, heartburn, or esophagitis (GERD)	☐ Seizures (epilepsy)
☐ Glaucoma	☐ Stroke (TIA)
☐ Heart attack (myocardial infarction)	☐ Underactive thyroid (hypothyroid)

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SECTION 4: Your nonprescription medications

Fill in the oval completely for each **nonprescription medication** that you are currently taking on a regular basis.

☐ Advil®/ibuprofen	☐ Prilosec OTC®/omeprazole
☐ Aleve®/naproxen	☐ Sominex®, Nytol®/diphenhydramine
☐ Bayer®/aspirin	☐ Tagamet®/cimetidine
☐ Benadryl®/diphenhydramine	☐ Tylenol®/acetaminophen
☐ Orudis KT®/ketoprofen	☐ Zantac®/ranitidine
☐ Pepcid AC®/famotidine	

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Additional health information

If you have any other medication allergies, medical conditions, or nonprescription medications not listed above, please call the Member Services phone number on the back of your member ID card.

Thank you very much.