





**WE WILL DISPENSE FDA-APPROVED GENERIC-EQUIVALENT MEDICATION WHEN AVAILABLE AND APPROPRIATE AS INDICATED ON YOUR PRESCRIPTION.**

**SECTION 5 New Prescription Order**

Fill out the information below and enclose new prescription(s) and payment with this form

<input type="text"/>	<input type="radio"/> Self	<input type="radio"/> Spouse	<input type="radio"/> Dependent	<input type="radio"/> Sex M / F	<input type="text"/>	<input type="text"/>
Patient First Name					Date of Birth	Doctor Phone Number
<input type="text"/>					<input type="text"/>	<input type="text"/>
Doctor Last Name					Drug Name	

<input type="text"/>	<input type="radio"/> Self	<input type="radio"/> Spouse	<input type="radio"/> Dependent	<input type="radio"/> Sex M / F	<input type="text"/>	<input type="text"/>
Patient First Name					Date of Birth	Doctor Phone Number
<input type="text"/>					<input type="text"/>	<input type="text"/>
Doctor Last Name					Drug Name	

<input type="text"/>	<input type="radio"/> Self	<input type="radio"/> Spouse	<input type="radio"/> Dependent	<input type="radio"/> Sex M / F	<input type="text"/>	<input type="text"/>
Patient First Name					Date of Birth	Doctor Phone Number
<input type="text"/>					<input type="text"/>	<input type="text"/>
Doctor Last Name					Drug Name	

**SECTION 6 Refills - Please send in refill slips for medications you would like to order. If you do not have your refill slip please complete the section below.**

**Print Prescription Number Here**  
 -   
**Drug Name:** \_\_\_\_\_

**Print Prescription Number Here**  
 -   
**Drug Name:** \_\_\_\_\_

**Print Prescription Number Here**  
 -   
**Drug Name:** \_\_\_\_\_

**Print Prescription Number Here**  
 -   
**Drug Name:** \_\_\_\_\_

**SECTION 7 Allergies & Health Conditions**

Complete this section only if adding a new customer or there are changes to existing customer Allergies or Health Conditions.

If no allergies are selected, for new customers, this indicates no known allergies. For existing customers, this indicates no change from information provided to Aetna Rx Home Delivery previously.

<input type="text"/>	<input type="text"/>
Cardholder's First Name	Date of Birth
<input type="text"/>	<input type="text"/>
Dependent's First Name	Date of Birth
<input type="text"/>	<input type="text"/>
Other Dependent's First Name	Date of Birth
<input type="text"/>	<input type="text"/>
Other Dependent's First Name	Date of Birth

Allergies								Health Conditions					
None	Penicillin	Sulfa	Codeine	Aspirin	Erythromycin	NSAIDS	Other (write in below)	Diabetes	High Blood Pressure	Asthma	GI/GERD	High Cholesterol	Other (write in below)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please write the person's name and list their Other Allergies and/or Health Conditions referenced above: \_\_\_\_\_

**Please Note:** By submitting this form you verify that the information is correct, that the prescriptions enclosed are for use by eligible participants and authorize the release of all information to the Plan Sponsor, administrator, or underwriter. All communications regarding this account will be directed to the member (employee/retired). If a spouse or other eligible dependent wishes to direct their communications to an alternate address or telephone number, they may make this request by completing the Confidential Communications Request form provided in the Privacy Notice, or as available on our website.