Use this form to order NEW and/or REFILL mail service prescriptions. Please print in BLUE or BLACK INK using CAPITAL letters only. FOR FASTEST SERVICE: Order refills and verify benefit information at www.caremark.com or call the number on your prescription benefit identification card.

### Address Change/Shipping Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Suffix (JR, SR)</th>
<th>Apt./Suite#</th>
<th>Use this address for this order only.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Street Address

City

State Zip Code

Prescription Plan Sponsor or Company Name

**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 number on your prescription benefit identification card.

**Applying Caremark Refill Label**

- Apply Caremark Refill Label here or write prescription number above

Alternatively:

- 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.

©2007 Caremark. All rights reserved.
Fill in for up to two individuals who will receive prescriptions with this order.

#1:

Last Name

First Name

Date of Birth: MM-DD-YYYY

Gender: M F

E-mail Address:

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)

Other:

Health Conditions: (Arthritis) (Asthma) (Diabetes) (GERD (Acid Reflux)) (Glaucoma) (Heart Condition)

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

☐ 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 Card Holder Signature Date

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

By submitting this form you acknowledge that eligibility under the prescription benefit is subject to plan verification and that you/your dependents do not have primary prescription coverage under any other plan.