Order Prescription Refills

To help ensure that your medication is ordered and received when you need it, each prescription order will contain a Refill Order Form and New Prescription and Update Information Form. In addition, each order will contain information regarding the earliest date that you can order a refill and the number of refills remaining on your prescription. If you selected Auto Refill, you will automatically receive your refill shipment at the appropriate time. If there are no refills remaining or your prescription is expired, you will also receive a Prescription Renewal Form in your prescription order. Give your prescriber your completed Prescription Renewal Form to provide the Prescription Information section and fax it to the number on the form.* In the event that your prescription, billing, or shipping information has changed, please complete and submit the New Prescription and Update Information Form.

Select one of the following prescription refill options:

- ***Online:*** Visit www.catalystrx.com/statemd. Enter your Member ID number (located on your prescription ID card) and Date of Birth in the "Members Login" box located on the right side of the screen. Then select "Mail Service Refills," found on the left side of the screen. Now you will be able to connect to Walgreens Mail Service by selecting the link, walgreensmail.com to order refills.
- ***E-prescribe*:*** If your prescriber has the technology to electronically prescribe medications, request that your refill be submitted in this way.
- ***Fax*:*** Give your prescriber your completed Prescriber Fax Form to provide the Patient Prescription Information section and fax it to the number listed on the form.
- ***Mail:*** Complete the Refill Order Form enclosed with your shipment and mail along with your copay.
- ***Phone:*** Call 800-797-3345. (Toll-free numbers for Spanish-speaking, deaf, and hard-of-hearing callers are on the back panel of this brochure.) Our 24-hour automated telephone system guides you through the refill-ordering process. Be sure to have your prescription number available.

Payment Information

We require payment with every prescription order. Shipment of your medication may be delayed if we do not receive payment in full at time of order or if your forms are not filled out completely. To make quick and secure online payments using your credit card, you will need to set up an online account at www.catalystrx.com/statemd. You may also make a payment by mailing a personal check or credit card information with your order, or by calling the Customer Care Center with your credit card information. If you'd like, we will keep your credit card information securely on file and charge current and future prescription orders to it. We accept all major credit cards.

Note: The Registration and Prescription Order Form and Prescriber Fax Form are available online at www.catalystrx.com/statemd.

*By law, faxed and e-prescribed prescriptions are valid only if sent from a prescriber's office.

For more information, visit
www.catalystrx.com/statemd

Walgreens Mail Service
P.O. Box 628001
Orlando, FL 32862-8001

Walgreens Customer Care Center
866-845-3590
Monday through Friday,
8:00 a.m. to 10:00 p.m. (EST),
Saturday and Sunday,
8:00 a.m. to 5:00 p.m. (EST)

En español: 800-778-5427
TTY: 800-573-1833

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Mail Service Pharmacy

Convenient, Reliable Delivery

Provided by

Walgreens Mail Service
Easy and convenient, your prescription benefit includes the use of Walgreens Mail Service. Choosing mail service allows you to enjoy delivery of your medications to the location of your choice.

Benefits of Mail Service
- Easy registration and ordering
- Quick delivery of medications in confidential, tamper-evident packaging; free standard shipping
- Important medication information included with every order
- Access to a pharmacist 24/7
- Our Customer Care Center offers:
  - Order, billing and shipping assistance
  - Technology for the deaf or hard of hearing
  - Over-the-phone translation services in more than 150 languages
- Auto Refill option
- Online account management and support

Safe and Accurate Prescription Orders
Our mail service pharmacies use advanced technology to help ensure accuracy. In addition, all prescription orders are carefully checked for potential medication interactions and correct dosage amounts. If necessary, our pharmacists will contact your prescriber with questions or concerns.

Save With Generic Medications
Generic medications offer the same benefits as their name-brand counterparts and usually cost significantly less. We review every prescription order to see if a less-expensive generic medication is available. Unless otherwise noted by your prescriber or state law, we will dispense an FDA-approved generic equivalent when available to help save you money. If you do not want a generic equivalent, please call our Customer Care Center at 866-845-3590 to advise.

The Walgreens Advantage
Because all of our retail and mail service pharmacies are electronically linked, any Walgreens pharmacist can answer your medication questions or fill an emergency prescription.

Getting Started
Register
Select one of the following options to register with Walgreens Mail Service. The information you provide is kept confidential and private in accordance with HIPAA and other applicable state privacy laws.

- ***Online:*** Visit www.catalystrx.com/statemd. Enter your Member ID number (located on your prescription ID card) and Date of Birth in the "Members Login" box located on the right side of the screen. Then select "Mail Service Refills," found on the left side of the screen. Now you will be able to connect to Walgreens Mail Service by selecting the link, walgreensmail.com. Select the "Register now" option on the left side of your screen. Fill in the required information, including your credit card information for billing purposes, and submit. Note that your prescription benefit provider/ pharmacy drug insurance is Catalyst Rx. Walgreens Mail Service will activate your account within 48 hours.

  After establishing your account with Walgreens Mail Service, you can order refills, check order status, view and print your prescription history, view your account balance, make payments, and receive secure information about your prescription order. We encourage you to establish an online account for all eligible family members.
- ***Fax*:*** Give your prescriber your completed Prescriber Fax Form to provide the Prescription Information section and fax it to the number listed on the form.
- ***Mail:*** Complete the Registration and Prescription Order Form included in your enrollment kit to submit with your first prescription.
- ***Phone:*** Call the Customer Care Center at 866-845-3590. You will be asked to provide your personal and insurance information, and report any allergies or health conditions you may have. (Toll-free numbers for Spanish-speaking, deaf, and hard-of-hearing callers are on the back panel of this brochure.)

Submit Your First Prescription Order
If you need to start taking your medication right away, request two prescriptions from your prescriber: one for an initial short-term supply of your medication (e.g., a 30-day supply or the amount allowed by your plan) that your local retail pharmacy can fill immediately, and a second for a 90-day supply, including three refills (or the maximum amount allowed by your plan). To maximize your pharmacy benefit and save money, ask your prescriber to write your prescription to allow for generic substitution.

Because we require the original written prescription from your prescriber to dispense and fulfill your medication, your first prescription may not be ordered online or by phone.

Select one of the following prescription order options:

- ***E-prescribe*:*** If your prescriber has the technology to electronically prescribe medications, request that your refill be submitted in this way.
- ***Fax*:*** Give your prescriber your completed Prescriber Fax Form to provide the Prescription Information section and fax it to the number listed on the form. If you have not already registered with Walgreens Mail Service, this form will combine your registration and first order into one step.
- ***Mail:*** Mail your completed Registration and Prescription Order Form along with your original prescription and copay.

Please allow 10 business days from the time that you place your order to receive your prescription(s).

To automatically receive refills of your medications, select the Auto Refill option on either the Prescriber Fax Form or Registration and Prescription Order Form. We will automatically refill your prescription at the appropriate time and bill the credit card you place on file. As medications may not be returned, if there is a change to your prescription, or to discontinue Auto Refill, please notify the Customer Care Center two weeks prior to your next refill date to avoid potential shipping and prescription charges.

Walgreens Mail Service

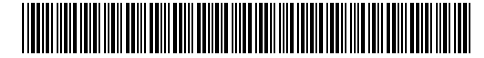
Registration and Prescription Order Form

State of Maryland

To quickly register, visit www.catalystrx.com/statemd.

Please print clearly using only **BLACK INK** and **UPPERCASE** letters.

Fill in the applicable circles completely (●). Not all Group and ID number boxes may be needed.



Member Information

○ Male
○ Female

Date of Birth [MM/DD/YYYY] ☐☐ / ☐☐ / ☐☐☐☐

Intercom: STMD **UPI#: SMD001**

Member ID Number (located on card)

Suffix (if on card)

Group Number: S T M D

Email Address *(to receive information regarding the processing of your order)*

Daytime Phone

Last Name

First Name

Evening Phone

Permanent Address 1

Permanent Address 2

City

State

ZIP Code

Prescriber Last Name

Prescriber First Initial

Prescriber Phone

Prescriber Fax

Dependent Information

○ Male
○ Female

Date of Birth [MM/DD/YYYY] ☐☐ / ☐☐ / ☐☐☐☐

Dependent Last Name

Dependent First Name

Suffix (if on card)

Prescriber Last Name

Prescriber First Initial

Prescriber Phone

Prescriber Fax

For separate shipping, please contact the Customer Care Center at 866-845-3590.

Email Address *(to receive information regarding the processing of your order)*

Please Complete

Member	Dependent	**Allergies**	Member	Dependent	**Health Conditions**
○	○	Aspirin	○	○	Arthritis
○	○	Cephalosporin	○	○	Asthma
○	○	Codeine derivatives	○	○	Diabetes
○	○	Morphine derivatives	○	○	Glaucoma
○	○	Penicillin	○	○	Heart disease
○	○	Sulfa drugs	○	○	Hypertension
○	○	None known	○	○	Pregnancy
○	○	Other (Use lines below.)	○	○	Thyroid disease
			○	○	None known
			○	○	Other (Use lines at left.)

Order Preference

Member	Dependent		Member	Dependent	
○	○	Easy-open caps	○	○	Spanish vial labels
○	○	Large-print vial labels	○	○	Auto Refill*

**only applies if mailing in enrollment form with a prescription enclosed*

1920000STMDSMD001

Member Alternate Shipping Information

If a dependent's medication needs to be delivered to a different address, please submit a separate form. Additional forms are available at www.catalystrx.com/statemd.

○ This shipment only ○ Temporary address change for dates indicated to the right Start Date [MM/DD/YY] __/__/__ End Date [MM/DD/YY] __/__/__

Alternate Address 1

Alternate Address 2

City State ZIP Code Alternate Phone – –

Order Information

Please allow 10 business days from the time that you place your order to receive your prescription(s). A refill order form and return envelope will be included with your shipment.

It is standard pharmacy practice to substitute generic equivalents for brand-name medications. Walgreens Mail Service will dispense an FDA-approved generic equivalent if available, permitted by your prescriber, and allowed by state law. If you do not want a generic equivalent or have questions regarding your mail service prescription(s), please call our Customer Care Center at 866-845-3590.

By submitting this form, you have authorized release of all information to Walgreens Mail Service (and other necessary parties) as required to process your order under your benefit plan.

Total number of prescriptions in this order ....

Total included for copay(s) ....$.

○ Regular Shipping NO CHARGE
○ Next Business Day ($17.95) $.
○ 2nd Business Day ($10.95) $.

Total Payment Due ....$.

Shipping prices may be subject to change by carrier without notification and may vary depending upon weight and zone.

Enclose your prescription(s) with this completed form and mail to:

Walgreens Mail Service
P.O. Box 628001
Orlando, FL 32862-8001

Payment Options *Payment is required at time of order. Please do not send cash.*

○ Check made payable to Walgreens Mail Service
○ Charge credit card below for this order only
○ Place credit card below on file for this and all future orders

We accept American Express®, Discover®, MasterCard®, and Visa®

Credit Card Number

Expiration Date [MM/YY] /

I authorize Walgreens Mail Service to charge my credit card for services for which I am financially responsible. If the credit card provided is not able to fulfill payment for any reason, I agree to pay my statement balance upon receipt of the statement and understand that failure to do so may result in discontinuation of pharmacy services.

Cardholder Signature ______________________ Date ____________

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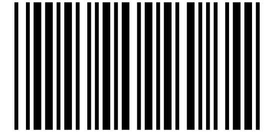
Prescriber Fax Form
State of Maryland

Intercom: STMD
UPI#: SMD001



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Please print clearly using only **BLACK INK** and **UPPERCASE** letters.
Fill in the applicable circles completely (●).

MEMBER SECTION

Use this form to have your prescriber submit a medication order or, if you are not yet registered for mail service, you can use this form to register and place your first order. After completing the member and/or dependent, shipping, and payment information, give both pages of the form to your prescriber to complete and fax. Credit card information is required to process your order. **Only faxes sent from a prescriber's office are valid.**

To automatically receive refills of your medications, select Auto Refill. By selecting this option, we automatically refill the prescription(s) at the appropriate time and bill your credit card on file. Most plans allow the convenience of Auto Refill. Check with your plan administrator to see if this is an option for you. As medications may not be returned, if there is a change to your prescription(s), or to discontinue Auto Refill, please notify the Customer Care Center two weeks prior to your next refill date to avoid prescription charges.

Member Information

Must be completed for each fax order.

○ Male ○ Female Date of Birth [MM/DD/YYYY] ______

Member ID Number (located on card) ______ Suffix (if on card) ______ Group Number S T M D

Last Name ______ First Name ______ Middle Initial ______

Address 1 ______

Address 2 ______

City ______ State ______ ZIP Code ______

Daytime Phone ( ) ______ Evening Phone ( ) ______

Email Address (to receive information regarding the processing of your order) ______

Dependent Information

Complete only if a prescription is included for the dependent.

○ Male ○ Female

Date of Birth [MM/DD/YYYY] ______

Suffix (if on card) ______

Group Number S T M D

Last Name ______

First Name ______

Middle Initial ______

Email Address (to receive information regarding the processing of your order)

______

For separate shipping, please contact the Customer Care Center at 866-845-3590.

Please Complete To Register

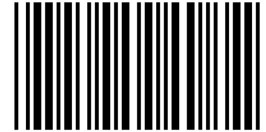
Note: If already registered, indicate any changes to member or dependent allergy and health conditions.

Member	Dependent	Allergies	Member	Dependent	Health Conditions
○	○	Aspirin	○	○	Arthritis
○	○	Cephalosporin	○	○	Asthma
○	○	Codeine derivatives	○	○	Diabetes
○	○	Morphine derivatives	○	○	Glaucoma
○	○	Penicillin	○	○	Heart disease
○	○	Sulfa drugs	○	○	Hypertension
○	○	None known	○	○	Pregnancy
○	○	Other (Use lines below)	○	○	Thyroid disease
			○	○	None known
			○	○	Other (Use lines at left)

Order Preference

○	○	Easy-open caps	○	○	Spanish vial labels
○	○	Large-print vial labels	○	○	Auto Refill

PMM-MC-PRD00004/S0059-0908



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Shipping Information

Must be completed by member. Please allow 10 business days for delivery from the date your prescriber faxes in your prescription(s). A refill order form and return envelope will be included with your shipment.

Total number of prescriptions in this order ☐☐ Total included for copay(s) $ ☐☐☐☐.☐☐

○ Regular Shipping — NO CHARGE
○ Next Business Day ($17.95) $ ☐☐.☐☐
○ 2nd Business Day ($10.95) $ ☐☐.☐☐

Total payment charged to credit card $ ☐☐☐☐.☐☐

A refill order form and return envelope will be included with your shipment.

Shipping prices may be subject to change by carrier without notification and may vary depending upon weight and zone.

Payment Information

Must be completed by member.

We accept American Express®, Discover®, MasterCard®, and Visa®

○ Charge credit card on file
○ Charge credit card below for this order only
○ Place credit card below on file for this and all future orders

Credit Card Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiration Date [MM/YY] ☐☐/☐☐

I authorize Walgreens Mail Service to charge my credit card for services for which I am financially responsible. If the credit card provided is not able to fulfill payment for any reason, I agree to pay my statement balance upon receipt of the statement and understand that failure to do so may result in discontinuation of pharmacy services.

Cardholder Signature ______________________ Date ______________

PRESCRIBER SECTION

IMPORTANT NOTICE: It is standard pharmacy practice to substitute generic equivalents for brand-name medications. Walgreens Mail Service will dispense an FDA-approved generic equivalent if available, permitted by your prescriber, and allowed by state law. If you do not want a generic equivalent or have questions regarding your mail service prescription(s), please call our Customer Care Center at 866-845-3590.

By submitting this form, you have authorized release of all information to Walgreens Mail Service (and other necessary parties) as required to process your prescriptions and refills under your benefit plan.

Prescription Information–MUST BE COMPLETED AND SIGNED BY PRESCRIBER. FAX NOT VALID FOR CII PRESCRIPTIONS.

Complete the prescription information and fax **BOTH** pages of the form to **Walgreens Mail Service at 888-595-1258.** Most prescription drug plans allow up to a 90-day supply with three refills.

Name of Patient ______________________ **Date of Birth [MM/DD/YYYY]** ______________

	Drug Name	Strength	Directions	Qty.	# of Refills	DAW
Rx 1						☐
Rx 2						☐
Rx 3						☐

Prescriber Signature ______________________

NPI# ______________________ DEA# ______________________
Required For Controlled Substances

Prescriber Name (Please Print) ______________________ Date ______________

Prescriber Phone ( ) ______________________ Prescriber Fax ( ) ______________

Confidential Health Information: Health care information is personal information related to a person's health care. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

IMPORTANT WARNING: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.

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