prescriptions
by mail drug program

Health Net®

What are the benefits of the mail order program?

Mail order offers the convenience of home delivery for most of your maintenance prescription needs.

WHAT CAN I EXPECT?

- Expect to receive your medication within 14 days after you mail your prescription.
- Prescriptions will be delivered to your home free of postage and handling charges. There is a charge, however, if you choose overnight mail service.
- Copayments can be made by check, money order, Mastercard, Visa, Discover or American Express.
- You can also order refills 24 hours a day, seven days a week. Simply call toll-free, **1-866-265-9455** (en español, 1-866-265-9456) and have your credit card ready.
- Call 1-866-265-9455 if you have questions regarding your order or need to speak to a pharmacist. For benefit questions, call Health Net Member Services at 1-800-522-0088.

WHO IS ELIGIBLE?

Most members with prescription drug benefits.

WHAT IS COVERED?

Most maintenance medications that by law require a doctor's prescription, and are covered under your prescription drug benefit. Maintenance medication refers to drugs needed for chronic or long-term conditions.

Certain controlled substances and all prior authorization drugs may be subject to dispensing limitations and to the professional judgment of the pharmacist. Once again, if you have any questions, call Express Scripts toll-free at 1-866-265-9455. Remember, the mail order prescription service is designed to complement and not replace the existing Health Net pharmacy network.

WHY GENERIC DRUGS?

Your plan requires generic drugs whenever possible. So keep in mind that every drug has a generic or "chemical" name. The brand name is the name under which the drug is marketed and sold. If there is an existing patent, the drug will not be available as a generic. But once a patent expires, any drug manufacturer obtaining FDA approval can sell the drug, usually at a much lower price, under its generic name. By law, generic and brand name drugs must meet the same standards for safety and efficacy.

HOW TO USE THE MAIL ORDER PRESCRIPTION PROGRAM

1. Ask your doctor for a prescription of up to a 90-day supply of medication. By law, Express Scripts can only fill your prescription with the quantity indicated on your prescription.

   Example: 1 a day = 90 tablets/capsules
   2 a day = 180 tablets/capsules
   3 a day = 270 tablets/capsules

2. Examine the prescription for the proper dosage, as well as the doctor's signature, state license number and DEA number.

3. Complete both the order form and patient profile questionnaire. The patient profile will only need to be completed with your first order. List all allergies, drug sensitivities and health conditions. Answer "none" if none applies.

4. Use the provided preaddressed, postage-paid envelope to mail the completed order forms, original prescriptions (no photocopies) and your copayments.

5. Prescriptions will be delivered postage-paid; most by first-class mail directly to your home. Please allow 14 days from the day you mail your order.

6. *Refills* – Place your refill order two weeks prior to the time your current supply of medication runs out. Include your refill number on the order form. Only the refills authorized by your physician can be filled.

7. Any questions or problems?
   Please call Express Scripts Customer Service at:
   1-866-265-9455
   1-800-972-4348 TDD
   24 hours a day, seven days a week

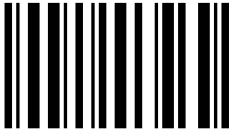
ORDER FORM AND CONFIDENTIAL PATIENT PROFILE

Please complete this form and return it to Express Scripts in the enclosed envelope.
Be sure to enclose your prescription(s) and copayment(s) or coinsurance(s). Please print or type all information.

Do not send your Health Net ID card.

Member information

Print member ID number in boxes (located on ID card)



YMX / HN4

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Dependent

First name ☐ Male ☐ Female

Last name

Date of birth (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___

Mailing address (please do not use P.O. box)

City

State ___ ___ ZIP code ___ ___ ___ ___ ___ – ___ ___ ___ ___

Phone number ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

Allergies:

☐ None (00) ☐ Aspirin (03) ☐ Tetracycline (07) ☐ Sulfa (15)
☐ Penicillin (01) ☐ Codeine (04) ☐ Erythromycin (09) ☐ Other

Health conditions:

☐ None (00) ☐ Diabetes (250.0) ☐ High cholesterol (272.0) ☐ Thyroid: LOW (244.9)
☐ Asthma (493.90) ☐ Depression (311) ☐ Hypertension (401.90) ☐ Other
☐ Arthritis (716.90) ☐ Glaucoma (365.9) ☐ Thyroid: HIGH (242.9)

Doctor's last name **Jean-Claude Hage, M.D.**

Doctor's phone number (very important) **9 0 9 – 8 8 6 – 4 9 1 7**

Child-proof safety cap is standard.

☐ Check here if you would like your prescriptions dispensed with NON-CHILD-RESISITANT (easy-open) caps.

IMPORTANT

It is standard pharmacy practice to substitute generic equivalents for brand name drugs whenever possible. You will receive generic substitutes, unless:

- your physician will not allow a generic substitute
- there is no generic substitute available*

If you elect to receive brand name drugs in place of generics, you may be responsible for the difference in cost between the brand name and the generic drug, in addition to your copayment or coinsurance.

*You will be billed the difference in your copayment or coinsurance amounts.

Payment (required at time of order)

Rx type	No.	Cost (ea.)*	Subtotal
Brand	___ ___	$ ___ ___ ___ ___ . ___ ___	$ ___ ___ ___ ___ . ___ ___
Generic	___ ___	$ ___ ___ ___ ___ . ___ ___	$ ___ ___ ___ ___ . ___ ___
TOTAL AMOUNT ENCLOSED			$ ___ ___ ___ ___ . ___ ___

*Please refer to your benefits plan for copayment amounts.

Please make check or money order payable to Express Scripts.

☐ My check or money order is enclosed.

Credit card # Expiration date

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ / ___ ___

Cardholder name _____

Please print name as it appears on your credit card.

Credit Card Authorization Signature _____

☐ I request that this and future orders be shipped "Signature Required.".

I certify that all the information on this form is correct, including any indications/elections made for sending my order Signature Required or Non-Child-Resistant (easy-open) caps. I permit Express Scripts Inc. to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment, or health care operations.

Signature Required _____

Mail form to: Express Scripts, P.O. Box 52069, Phoenix, AZ 85072-9935