



**Mail Service Prescription Drug Program Order Form**  
Administered by **BioScrip**

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**I. PATIENT INFORMATION**

Last \_\_\_\_\_  
 First \_\_\_\_\_ M. Initial \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Male \_\_\_ Female \_\_\_  
 Home Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_  
 Shipping Address (if different):  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 E-mail \_\_\_\_\_

**II. HEALTH INFORMATION**

• **Allergies:** Yes/ No  
 If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

• **Medical Conditions:** Yes/ No  
 If Yes please list: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**V. PRESCRIPTION INFORMATION**

I am enclosing new original prescriptions written by my physician for the medications listed below.  
 I choose to REFILL the medications that I have received from BioScrip previously using this form. **Or SAVE TIME by our 24-hour refill line at 1-800-926-2455**

Patient Name	Medication Name, Strength, Quantity	Doctor's Name	Doctor's Phone #	REFILLS (refill #)
1.				
2.				
3.				
4.				
5.				
6.				

**VI. PATIENT AUTHORIZATION**

I certify that the information on this form is correct, and authorize release of Information regarding my medical and prescription drug history my program sponsor of the prescription drug program.

Date \_\_\_\_\_ Signature \_\_\_\_\_

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**III. INSURANCE INFORMATION**

**Cardholder Name**  
 \_\_\_\_\_  
 (If different from patient)  
 Relationship: self spouse child other  
**Member ID #**  
 \_\_\_\_\_  
**Insurance Plan/Group name**  
 \_\_\_\_\_

**IV. PAYMENT OPTIONS**

Credit Card: American Express MasterCard  
Discover Card Visa  
 Name listed on Card:  
 \_\_\_\_\_  
 Credit Card # \_\_\_\_\_  
 Exp. Date \_\_\_\_\_  
 Signature \_\_\_\_\_

(Signature authorizes **BioScrip** to charge my credit card)

Check # \_\_\_\_\_ amount included: \$ \_\_\_\_\_  
 Money Order # \_\_\_\_\_ amount included: \$ \_\_\_\_\_  
 (Make check/money order payable to: Bioscrip)  
 P. O. Box 1778, Columbus, OH 43216

**PAYMENT MUST ACCOMPANY ORDER**



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### INSTRUCTIONS FOR ORDERING YOUR MAINTENANCE MEDICATIONS

#### For New Prescriptions:

- Please fill out the order form **completely** and print clearly. Use one order form for each patient ordering medication(s). **Missing information delays the processing of your order.**
- If using a credit card, be sure to include your credit card number. **Bioscrip** cannot process or ship your order without payment in full. If you know your copayment, you can also pay by personal check or money order.
- **BioScrip** provides *free* standard shipping for prescriptions. If you choose to have your Medication shipment rush-ordered, additional costs will apply.
- Pharmacy Regulations prohibit **BioScrip** from honoring requests to cancel or return Prescription orders after the order has been received.

**For Refills:** If your medication was previously filled by **BioScrip** check the label for the RX#. You can have it refilled by calling toll-free **1-800-677-4323 (1-877-517-9301** for TTY service). Choose “refill my medication” and follow the instructions.

### MEDICATION SUPPLY CONSIDERATIONS

Be sure to place your order at least 21 days before you run out of your current medication supply. Your benefit plan requires your doctor to write a prescription for a 90-day supply. If you need a prescription fulfilled immediately, ask your doctor to write a 30-day prescription that you can have filled at your local pharmacy, and a 90-day prescription for you to send to **BioScrip**. (Please note: If your doctor specifies a quantity less than 90 days, it will be filled as written on the prescription. For example: if the prescription specifies a 30-day supply, **Bioscrip** will fill the prescription for 30 days.)

### BENEFIT INFORMATION

**BioScrip** must adhere to your benefit plan. If an order cannot be processed due to benefit plan stipulations, **BioScrip** will contact you. Call the Member Services phone number provided on the back of your prescription benefit identification card if you have questions about your drug benefits or copayments.

### VISIT OUR ONLINE DRUGSTORE

While you're online, be sure to visit our Online Drugstore to save on your favorite health and beauty products. Enjoy the convenience of having your favorite products delivered directly to your door. It's easy. At our home page [www.scrippharmacy.com](http://www.scrippharmacy.com) just click on “**Online Drugstore**,” choose “Health & Beauty,” and start shopping! Your discount will appear at the checkout stage of your order. Once you have had your prescription filled at **BioScrip** you can place refill request on-line as well.

#### **If you have Questions about placing your order or your order status?**

Call us toll-free at **1-800-677-4323 (1-877-517-9301** for TTY service).

**BioScrip**  
P.O. Box 1778  
Columbus, OH 43216

**Hours of Operation:**  
Seven Days a Week  
24 Hours a Day