



Discover the convenience of the
**OptumRxTM Mail
Service Pharmacy**

As part of your pharmacy benefit, you may be able to save money and time by using the mail service pharmacy.



Personalized attention, safety, and savings – the advantages of the OptumRx™ Mail Service Pharmacy.

Depending on your benefit plan, you could save money by ordering a 3-month supply of medication for just one mail-order copayment/coinsurance*. Your medications are shipped to you with standard shipping at no cost to you.

Help managing your ongoing medications

You will have 24/7 access to pharmacists who are trained on the medications used to treat a specific condition, such as diabetes. They are available by phone to review your medications. If there is a potential problem, an OptumRx pharmacist will contact your doctor.

With mail service you'll get:

- ▶ 24/7 phone access to pharmacists
- ▶ Information about potential lower-cost medication options
- ▶ Standard shipping at no cost to you
- ▶ A state-of-the-art dispensing process with multiple quality checks for safety and accuracy



Getting started is simple and easy



Online:

- ▶ Log on to myuhc.com®
- ▶ Click on "Manage My Prescriptions" and select "Transfer Prescriptions."
- ▶ Select the medications you would like to transfer to the mail service pharmacy.



By mail:

- ▶ Ask your doctor for a new prescription for up to a 3-month supply, plus refills for up to one year (if appropriate).
- ▶ Go to myuhc.com and download an order form
- ▶ Mail the new prescription and order form to the address provided



By fax:

- ▶ Ask your doctor for a new prescription as described above.
- ▶ Your doctor can call 1-800-788-4863 for instructions to fax prescription(s) directly to the OptumRx Mail Service Pharmacy. (NOTE: Faxed prescriptions can only be accepted from your doctor's office.)

Once OptumRx receives your complete order for a new prescription, your medications should arrive within ten business days – completed *refill* orders should arrive in about seven business days. If you need your medication right away, ask your doctor for a 1-month supply prescription you can fill at a participating retail pharmacy.

Frequently Asked Questions

1. Can the OptumRx Mail Service Pharmacy help me save money compared to a retail pharmacy?
Yes, most plans entitle members to a lower copay when they receive their medications through the mail service pharmacy.
2. Does the OptumRx Mail Service Pharmacy have other ways to help me keep costs down?
Yes. One way is by identifying less expensive alternatives to brand-name medications that you may discuss with your doctor.
3. Can the OptumRx Mail Service Pharmacy ship medications that need refrigeration?
Yes. Perishable medications are shipped expedited at no charge in temperature-controlled packages when appropriate.
4. How are medications sent through the mail?
All medications are sealed helping to protect your safety and privacy.

For more information, call the toll-free member phone number on the back of your health plan ID card or visit myuhc.com.[®]



myuhc.com

If you currently have UnitedHealthcare pharmacy benefits administered by Medco, OptumRx™ Mail Service Pharmacy will be the mail order pharmacy for new business after January 1, 2012, and for current UnitedHealthcare customers after their transition to OptumRx pharmacy benefit services in 2013.

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104-0008 1/13 Consumer C1236-01

New Prescription Fax Order Form

1 Please fill out Section 1, then have your physician fill out Section 2 and FAX it to 1-800-491-7997.
NOTE: THIS FAX IS VOID UNLESS RECEIVED DIRECTLY FROM YOUR PHYSICIAN'S OFFICE.

Primary Member ID Number		(Additional coverage, if applicable) Secondary Member ID Number	
Last Name		First Name	MI
Delivery Address			Apt. #
City	State	ZIP	Phone Number with Area Code
Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Email	
Medication Allergies: <input type="checkbox"/> Amoxicil/Ampicillin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Aspirin <input type="checkbox"/> NSAIDs <input type="checkbox"/> Cephalosporins <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Quinolones		Health Conditions: <input type="checkbox"/> Arthritis <input type="checkbox"/> Glaucoma <input type="checkbox"/> Asthma <input type="checkbox"/> Heart Condition <input type="checkbox"/> Cancer <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> None Known <input type="checkbox"/> Sulfa <input type="checkbox"/> Tetracyclines <input type="checkbox"/> Others: _____		<input type="checkbox"/> None Known <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Others: _____	
Over-the-counter/Herbal medications taken regularly:			

Keep on file. Do not ship. If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them here:

Notes to Pharmacy:

<p>2 PHYSICIAN — Please <u>fill out</u> Section 2, or <u>attach</u> your office prescription to this form. Then FAX to 1-800-491-7997</p> <p>Physician-Only Phone: 1-800-791-7658</p> <p>This document, including any attachments, contains personal and sensitive information related to a person's health care. The information contained in this document is intended only for the sole use of OptumRx. If you are not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the contents of this information is strictly prohibited and will be vigorously prosecuted.</p> <p>If you have received this document in error, please immediately notify the sender, or OptumRx by phone or fax at the numbers listed above.</p>	Patient Name	DOB
Refills <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Other: _____ Dispense as written <input type="checkbox"/> Yes		

Physician Name	Office Phone Number with Area Code	
Street Address	Fax Number with Area Code	
City, State, ZIP	NPI	DEA
Physician Signature	Date	



New Prescription Fax Order Form

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NOTE: THIS FAX IS VOID UNLESS RECEIVED DIRECTLY FROM YOUR PHYSICIAN'S OFFICE.

Primary Member ID Number		(Additional coverage, if applicable) Secondary Member ID Number	
Last Name		First Name	MI
Delivery Address			Apt. #
City	State	ZIP	Phone Number with Area Code
Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Email
Medication Allergies: <input type="checkbox"/> Amoxicil/Ampicillin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Aspirin <input type="checkbox"/> NSAIDs <input type="checkbox"/> Cephalosporins <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Quinolones		Health Conditions: <input type="checkbox"/> Arthritis <input type="checkbox"/> Glaucoma <input type="checkbox"/> Asthma <input type="checkbox"/> Heart Condition <input type="checkbox"/> Cancer <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol	

Over-the-counter/Herbal medications taken regularly:

Keep on file. Do not ship. If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them here:

Notes to Pharmacy:

2 **PHYSICIAN —**
 Please fill out Section 2,
 or attach your office prescription
 to this form.
 Then FAX to 1-800-491-7997
Physician-Only Phone:
1-800-791-7658

This document, including any attachments, contains personal and sensitive information related to a person's health care. The information contained in this document is intended only for the sole use of OptumRx. If you are not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the contents of this information is strictly prohibited and will be vigorously prosecuted.

If you have received this document in error, please immediately notify the sender, or OptumRx by phone or fax at the numbers listed above.

Patient Name	DOB
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Rx

Refills 1 2 3 Other: _____ Dispense as written Yes

Physician Name	Office Phone Number with Area Code	
Street Address	Fax Number with Area Code	
City, State, ZIP	NPI	DEA
Physician Signature	Date	





NEW PRESCRIPTION MAIL-IN ORDER FORM

1 Member and physician information — please use black or blue ink

Primary Member ID Number		(Additional coverage, if applicable) Secondary Member ID Number	
Last Name		First Name	Mi
Delivery Address			Apt. #
City	State	ZIP	Phone Number with Area Code
Date of Birth (mm/dd/yyyy)	Gender <input type="radio"/> M <input type="radio"/> F	Email	
Physician Name			Physician Phone Number with Area Code

2 Health history

Medication Allergies:

<input type="radio"/> None known	<input type="radio"/> Aspirin	<input type="radio"/> Erythromycin	<input type="radio"/> Quinolones	<input type="radio"/> Others: _____
<input type="radio"/> Amoxicil/Ampicillin	<input type="radio"/> Cephalosporins	<input type="radio"/> NSAIDs	<input type="radio"/> Sulfa	_____
	<input type="radio"/> Codeine	<input type="radio"/> Penicillin	<input type="radio"/> Tetracyclines	_____

Health Conditions:

<input type="radio"/> None known	<input type="radio"/> Asthma	<input type="radio"/> Glaucoma	<input type="radio"/> High cholesterol	<input type="radio"/> Others: _____
<input type="radio"/> Arthritis	<input type="radio"/> Cancer	<input type="radio"/> Heart condition	<input type="radio"/> Osteoporosis	_____
	<input type="radio"/> Diabetes	<input type="radio"/> High blood pressure	<input type="radio"/> Thyroid Disease	_____

Over-the-counter/herbal medications taken regularly:

3 Pharmacy processing

Generic substitution. FDA-approved generic equivalents will be dispensed for brand-name drugs whenever possible, unless you or your physician indicate otherwise. Brand-name medications may be subject to a higher cost. **If you require brand-name medications, please list those medications here:**

Keep on file. If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them here:

Notes to pharmacy:

4 Payment and shipping information — do not send cash

Standard delivery is included at no charge. New prescriptions should arrive within about 10 business days from the date the completed order is received. Completed refill orders should arrive within about 7 business days. OptumRx will contact you if there will be an extended delay in delivering your medications.

You may log on to www.myuhc.com to see if drug pricing information is available before enclosing payment. Once shipped, medications may not be returned for a refund or adjustment.

- Ship overnight.** Add \$12.50 to order amount (subject to change).
- Check enclosed.** All checks must be signed and made payable to: OptumRx.
- Charge to my credit card on file.**
- Charge to my NEW credit card.**

New Credit Card Number

Expiration Date (Month/Year)

____/____

Visa, MasterCard, AMEX and Discover are accepted.

Signature: _____

Date: _____

For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance and other such expenses related to prescription orders. By supplying my credit card number, **I authorize OptumRx to maintain my credit card on file as payment method for any future charges.** To modify payment selection, contact customer service at any time.

5 Mail this completed order form with your new prescription(s) to OptumRx, P.O. Box 2975, Mission, KS 66201. DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.

