To ensure fast delivery, please verify your prescriptions before you leave the physician’s office to make certain that:

- The physician’s name is legible.
- The patient’s name is legible.
- The exact daily dosage is specified.
- The exact strength is specified.
- A 90-day supply quantity is indicated.
- The number of refills will last for 1 year.

**Refill by Phone**

Call our Refill by Phone Interactive Voice Center at: 800-662-0586 using a touch tone phone. Please have the prescription number, which is located on the prescription bottle, available when calling.

**Refills by Internet**

To refill prescription(s) online, simply complete the Refill Request Form that is located at www.procarerx.com. Choose the ‘Mail Order Refills’ option listed on the left-hand side of the page under the Quick Links panel.

**Refill by Mail**

- Complete all sections on the reverse side.
- Enclose payment amount (if applicable).
- Mail your request using the enclosed envelope to:
  
  ProCare PharmacyCare
  3891 Commerce Pkwy
  Miramar, FL 33025

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**Customer Care Center:**

800-662-0586

Fax: 800-662-0590

TTY Line: 711

Monday through Friday
8:00 am to 8:00 pm (ET)
Saturday 9:00 am to 1:00 pm (ET)

HomeDelivery@ProCareRx.com

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**ProCare PharmacyCare**

Miramar, FL
Las Vegas, NV

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**HST Pharmacy**

Gainesville, GA

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800-662-0586

TTY Line: 711

HomeDelivery@ProCareRx.com
Enjoy These Benefits

A 90-day supply of your medication may be available at a lower copay than you would pay at your retail pharmacy. Refilling your prescription is easy when using the following options:

Website: www.ProCareRx.com
(Click on ‘Mail Order Refills’ under the Quick Links panel)

For faster service on a new prescription, ask your physician to call 800-662-0586 or fax to 800-662-0590

All prescriptions are screened for potential interactions and allergy sensitivity based on the information you provide in your patient profile.

Order Form for New Participants:

Prescriptions are for:
□ Member  □ Spouse  □ Dependent

Member #:_________________________________________
Please write the Member ID, Date of Birth, and your address on the back of each prescription.
□ Check here if you would like non-childproof caps with your order. (Childproof caps are used on all prescription orders for safety during shipping.)

Payment Method
□ Check (See invoice for payment information)
□ Money Order  □ Visa  □ MasterCard

Name (as it appears on card):
____________________________________________________

Account #:_________________________________________
Signature:__________________________________________
Expiration date:____________ Date:____________
□ Check here if you do not want future orders charged to this credit card which will be placed on file.

Patient Profile and Order Form

Instructions for new members: first time users of ProCare Rx Home Delivery program must complete all sections of this form.

Member name:_________________________ Date of birth:_________ □ Male □ Female
Address:________________________________________________________________________ Apt. #:_________
City:_________________________ State:_______ Zip:________________________
Home phone:_________________________ Cell phone:________________________ Best time to call:_____
Alternative phone:_________________________ Email address:_________________________

By providing your email address you are granting ProCare Rx permission to contact you via email regarding your prescription drug coverage.

Allergies: □ None  □ Penicillin  □ Erythromycin  □ Sulfur  □ Aspirin  □ Other __________
Health Conditions: □ Asthma  □ Cholesterol  □ Depression  □ Diabetes  □ Heart Failure
□ Thyroid  □ Stomach Ulcer/Reflux  □ High Blood Pressure  □ Other:________________________

If diabetic, indicate brand used for diabetic supplies:
Monitor:_________________________ Lancets:_________________________ Test strips:_________________________

Spouse name:_________________________ Date of birth:_________ □ Male □ Female
Allergies: □ None  □ Penicillin  □ Erythromycin  □ Sulfur  □ Aspirin  □ Other __________
Health Conditions: □ Asthma  □ Cholesterol  □ Depression  □ Diabetes  □ Heart Failure
□ Thyroid  □ Stomach Ulcer/Reflux  □ High Blood Pressure  □ Other:________________________

If diabetic, indicate brand used for diabetic supplies:
Monitor:_________________________ Lancets:_________________________ Test strips:_________________________

Dependent name:_________________________ Date of birth:_________ □ Male □ Female
Allergies: □ None  □ Penicillin  □ Erythromycin  □ Sulfur  □ Aspirin  □ Other __________
Health Conditions: □ Asthma  □ Cholesterol  □ Depression  □ Diabetes  □ Heart Failure
□ Thyroid  □ Stomach Ulcer/Reflux  □ High Blood Pressure  □ Other:________________________

If diabetic, indicate brand used for diabetic supplies:
Monitor:_________________________ Lancets:_________________________ Test strips:_________________________

CERTIFICATION — PLEASE READ AND SIGN: I CERTIFY THAT THE INFORMATION PROVIDED IN THIS FORM IS CORRECT, AND I AUTHORIZE THE RELEASE OF ALL INFORMATION TO THE HEALTH INSURANCE PLAN, ADMINISTRATOR, OR UNDERWRITER. I AUTHORIZE ProCare PharmacyCare, LLC or HST Pharmacy to substitute Generic drugs in all cases when legally permissible in accordance with applicable law, and consistent with the Doctor’s orders.

__________________________________________
Signature

__________________________________________
Date