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 interactive voice center at 800-662-0586. Please have the Rx number available, located on the medication bottle, 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

Customer Care Center:

800-662-0586

Fax: 800-662-0590

TTY Line: 711

Monday through Friday

8:00 AM – 8:00 PM / ET

HomeDelivery@ProCareRx.com

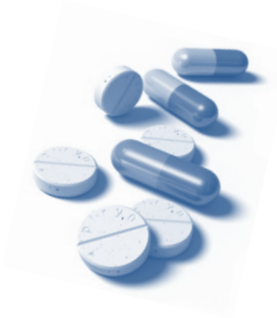
ProCare PharmacyCare

Miramar, FL

Las Vegas, NV

HST Pharmacy

Gainesville, GA



ProCare Rx

Prescription Order Form and Patient Profile for New Members

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, as it will be placed on file.*

Patient Profile and Order Form

Instructions for new members: first time users of ProCare Rx's 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:_____

Email address:_____ Best time to call:_____

By providing your phone numbers and email address, you are granting ProCare permission to contact you regarding your prescription benefits and any refill authorizations.

Allergies: ☐ None ☐ Penicillin ☐ Erythromycin ☐ Sulfa ☐ 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 ☐ Sulfa ☐ 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 ☐ Sulfa ☐ 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 where legally permissible in accordance with applicable law and consistent with the doctor's orders.

_____

Signature Date