Mail Service Pharmacy Tips

- Complete attached registration form.
- New prescriptions must be mailed to the mail service pharmacy or faxed from your doctor's office on the Walgreens Mail Service doctor fax form.
- For long-term medications you need right away: ask your doctor for two prescriptions—one for up to a 30-day supply to fill at a participating retail pharmacy, and one for up to a 90-day supply to fill through the mail.
- If two or more prescriptions are sent in for multiple family members, the prescriptions will be shipped, as a single order, to an adult family member at the address given on the order form. If you prefer different shipping arrangements for privacy or other reasons, please contact our Customer Care Center.
- Most orders are shipped by U.S. Postal Service. Controlled substances may require an adult signature upon receipt. Packaging does not show any indication that medications are enclosed.
- Your prescription(s) may be filled for up to a 90-day supply when allowed by your physician, the law, and in accordance with pharmacy practice. Some medications may only be dispensed for the exact quantity as written by your physician.
- Include payment, if applicable to avoid any delays. Please do not send cash.
- Make checks payable to Walgreens Mail Service. Credit cards accepted.
- Allow 2 weeks for delivery.

Customer Care Center:
1-866-854-8851 (TTY: 1-800-573-1833)
Monday–Friday: 8:00 a.m.–10:00 p.m. (Eastern)
Saturday–Sunday: 8:00 a.m.–5:00 p.m. (Eastern)

Refills by Phone Available 24/7:
1-866-854-8851 (TTY: 1-800-573-1833)

Internet:
www.catalystrx.com

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REGISTRATION & PRESCRIPTION ORDER FORM

Use black ink only. Enclose form with prescription(s) and payment.

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Walgreens Mail Service **Sandia National Laboratories**

MEMBER INFO. ☐ Male ☐ Female ☐ Patient needs snap-on caps ☐ Patient needs Spanish vial labels

Group Number S A N D I A | Intercom UPI # SANDIA SNL001

ID Number (from card) | Suffix if on card

Name (First, Last) | Date of Birth (MM/DD/YYYY) / /

Shipping Address (Please do not use P.O. Box) | Daytime Phone ( )

City | State | ZIP Code | Evening Phone ( )

E-mail Address | Dr. Name | Dr. Phone (Required) ( )

ALLERGIES: ☐ No known ☐ 32-Codeine ☐ 70-Penicillin ☐ 87-Sulfa ☐ 93-Tetracycline ☐ Other (list):

HEALTH CONDITIONS: ☐ No known ☐ 200-Diabetes ☐ 300-Hypertension ☐ 400-Heart disease ☐ 500-Glaucoma ☐ 600-Stomach disorders ☐ 700-Thyroid disease ☐ 800-Arthritis ☐ Other (list):

PAYMENT – CHECK OR CREDIT CARD (VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS)

It is standard pharmacy practice to substitute generic equivalents for brand-name drugs whenever possible. Walgreens Mail Service will dispense an FDA-approved generic equivalent whenever available, permitted by your prescriber, and allowable by law. If you do not want a generic equivalent, please call our Customer Care Center to advise. 09-07

Rx Type	No.	Cost (ea.)	Subtotal
Generic		*	$
Brand		*	$
			$
			$

Credit Card Number

Credit Card Expiration (MM/YY) / *Please refer to your Plan Document or contact Catalyst Rx for copay amounts.

Mail to: Walgreens Mail Service, P.O. Box 29061, Phoenix, AZ 85038-9061

Turn page and complete dependent info. on the other side of this form.

Thank you for your order.

DEPENDENT INFORMATION ☐ Male ☐ Female ☐ Patient needs snap-on caps ☐ Patient needs Spanish vial labels

ID No. if on card | Suffix if on card

Name (First, Last) | Date of Birth (MM/DD/YYYY)

Shipping Address (if different than member) | Daytime Phone ( )

City | State | ZIP Code | Evening Phone ( )

E-mail Address | Dr. Name | Dr. Phone (Required) ( )

ALLERGIES: ☐ No known ☐ 32-Codeine ☐ 70-Penicillin
☐ 87-Sulfa ☐ 93-Tetracycline ☐ Other (list):

HEALTH CONDITIONS: ☐ No known ☐ 200-Diabetes ☐ 300-Hypertension
☐ 400-Heart disease ☐ 500-Glaucoma ☐ 600-Stomach disorders
☐ 700-Thyroid disease ☐ 800-Arthritis ☐ Other (list):

DEPENDENT INFORMATION ☐ Male ☐ Female ☐ Patient needs snap-on caps ☐ Patient needs Spanish vial labels

ID No. if on card | Suffix if on card

Name (First, Last) | Date of Birth (MM/DD/YYYY)

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☐ 87-Sulfa ☐ 93-Tetracycline ☐ Other (list):

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☐ 400-Heart disease ☐ 500-Glaucoma ☐ 600-Stomach disorders
☐ 700-Thyroid disease ☐ 800-Arthritis ☐ Other (list):

Please Note: By submitting this form, you have authorized release of all information to Walgreens Mail Service (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan.

This brochure only highlights your mail service pharmacy benefit. In case of any discrepancy between this brochure and the legal documents describing the plan, the legal documents govern.

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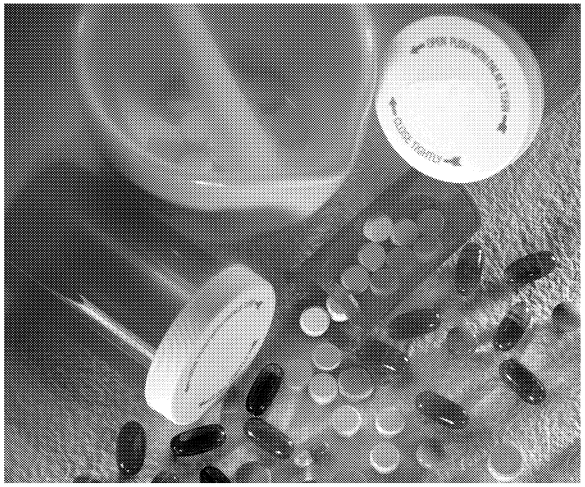
Sandia National Laboratories

Mail Service Pharmacy

Prescription Order Form



Provided by

CatalystRx® A HealthExtras® Company

Walgreens Mail Service

Rx FOR: _____ DATE: _____

ADDRESS: _____ TEL: _____

Facsimile Not valid for CII prescriptions
Valid only at Walgreens Mail Service

Dr: _____ Dr: _____
DISPENSE AS WRITTEN SUBSTITUTION PERMISSIBLE MAY SUBSTITUTE

PHYSICIAN NAME (PLEASE PRINT): _____

REFILL _____ TIMES ADDRESS _____

DEA # _____ TELEPHONE # _____

000001

Rx FOR: _____ DATE: _____

ADDRESS: _____ TEL: _____

Facsimile Not valid for CII prescriptions
Valid only at Walgreens Mail Service

Dr: _____ Dr: _____
DISPENSE AS WRITTEN SUBSTITUTION PERMISSIBLE MAY SUBSTITUTE

PHYSICIAN NAME (PLEASE PRINT): _____

REFILL _____ TIMES ADDRESS _____

DEA # _____ TELEPHONE # _____

FAX ORDER FORM

Sandia National Laboratories

1 0 9

INTERCOM: SANDIA **UPI NO.: SNL 001**

PHYSICIAN: Please fax fully completed form to Walgreens Mail Service: **1-800-332-9581.**
TO THE PATIENT: Please make every attempt to obtain a new written prescription from your doctor and send it with an order form and payment to:

Walgreens Mail Service, P.O. Box 29061, Phoenix, AZ 85038-9061
Customer Care Center: 1-866-854-8851 (TTY for hearing impaired: 1-800-573-1833)

If you are unable to make an appointment with your doctor, follow these steps to obtain your prescription:

- Fully complete the sections below using **black ink** only.
  A credit card number is required at the time the form is submitted.
- Have your doctor supply the prescription information requested using prescriber's form.
- Have your doctor fax the form to the number above.
  IMPORTANT: To be valid, the prescription must be faxed from your doctor's office.
- Please allow 2 weeks for delivery from the date your physician faxes your prescription in.

PLEASE NOTE: By submitting this form, you have authorized release of all information to Walgreens Mail Service (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan.

MEMBER INFORMATION

ID Number (located on ID card) | Suffix if on card

Group Number: S A N D I A | Date of Birth: / /

Name (First, Last) | E-mail Address

Address (please do not use P.O. box) | Daytime Phone ( )

City | State | Zip Code | Evening Phone ( )

PATIENT INFORMATION

Patient Name (First, Last if different from above) | ☐ Male ☐ Female | Patient Date of Birth (Mo/Day/Yr) / /

Patient E-mail Address

PATIENT ALLERGIES:
☐ No Known ☐ 32-Codeine
☐ 70-Penicillin ☐ 87-Sulfa
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☐ No Known ☐ 200-Diabetes ☐ 300-Hypertension
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PAYMENT INFORMATION

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CREDIT CARD NUMBER (VISA, MasterCard, Discover, American Express) CREDIT CARD EXP. /