

# PRESCRIPTION DRUG PROGRAM MAIL SERVICE FORM

Mail Order Prescriptions Made Easy!

## **HOW TO ORDER NEW MEDICATION**

This form is only needed for first time orders, dependents who have been added since the last order, or changes to current information. Be sure to complete your method of payment.

To begin ordering your maintenance prescription medications from the WellDyneRx Mail Service Pharmacy, enroll using one of the following options.

#### Option 1

Enroll online at **www.myWDRX.com**. Mail your prescriptions to WellDyneRx or have your **prescriber** fax them to 888-830-3608.

### Option 2

Enroll by completing this form and mailing it to WellDyneRx, PO Box 3129, Englewood, CO 80155.

Include your prescriptions with this form or have your **prescriber** fax them to 888-830-3608.

Remember to write your **Member ID** and **Date of Birth** on your prescriptions.

### Please Note: Only prescribers may fax prescriptions to a pharmacy.

WellDyneRx will dispense the days supply as written by the prescriber. For example, if your prescription is written for 30 days and your plan allows 30 day fills at mail order, WellDyneRx will fill the 30 day supply as written. If your prescription is written for 30 days, and your plan only allows 90 days, we will contact you regarding the status of your order and how to best meet your needs.

To save time, please look at your prescription before you leave your prescriber's office. Check the drug name, quantity and days supply. The days supply should match the number of days you want us to provide with each refill. Please review your Plan benefits for the maximum days supply your Plan will allow with each mail order refill.

### **HOW TO ORDER REFILLS**

To place a refill order, please visit www.myWDRX.com or call 866-490-3326 prompt 2 approximately three weeks prior to depletion of your medication supply.

#### SAVINGS

Mail Service can save you money. To find out the cost for your mail order medication, contact our Member Services team.

Where appropriate, WellDyneRx uses generic medications to fill your prescriptions. The FDA requires that all drugs be safe and effective. Since generics use the same active ingredients and are shown to work the same way in the body, they have the same risks and benefits as their brand name counterparts.

## **QUALITY IS OUR FIRST PRIORITY**

The WellDyneRx Mail Service Pharmacy is staffed by registered pharmacists and certified pharmacy technicians. With advanced robotics and state-of-the-art technology, our highly trained professionals conduct multiple quality and accuracy checks on your order.

Your prescription order will be shipped using US Mail or UPS. Refrigerated items are shipped in accordance with FDA and manufacturers' specifications. For your security, some controlled substances are shipped UPS Ground with a tracking number and may require a signature.

## **CONTACT INFORMATION**

## WellDyneRx

PO Box 3129, Englewood, CO 80155 Toll-Free Phone: 866-490-3326 Toll-Free TTY: 800-900-6570 Toll-Free Fax: 888-830-3608 www.myWDRX.com

Hours of Operation: 24 hours a day, 7 days a week

MAIL	SERVICE EN	ROLLMENT FORM		
Cardholder's Last Name	First Name	<u>,</u>	Middle Initial Date	of Birth (mm/dd/yy)
				//
Primary Address	City		State	Zip Code
Shipping Address (if different than Primary Address	s) City		State	Zip Code
Primary Phone	Secondary	Phone		
Member E-mail Address				
Group Name (Primary)	Group ID#	Member ID#		
Group Name (Secondary)	Group ID#	Member ID#		
Please Charge My: ☐ Visa ☐ MasterCard Credit Card #:	☐ Discover ☐	American Express Expiration Date		
C11112N		C:*		
Cardholder's Name:		Signature*		

Member Information						_ :	Drug	g Al	lerg	ies		He	ealth	1 C	nd	<u>itio</u>	ns	
1. Primary Cardholder's First Name	<b>M M</b>	Date (	of Bir	th Y Y	A Male/Female(M/F)		None Amoxicillin	Aspirin Cephalosporins	Codeine Frythromycin	Penicillin	Suna Tetracyclines Other (Specify)**	None (-F )	Asthma Bleeding Disorder	COPD COPD	Diabetes	GERD/UIcer High Chalesteral/Heart Disease	Hypertension	Liver Disease Renal Disease
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2. Spouse's First Name																		
			/															
3. Other Dependent's First Name																		
		,	/															
4. Other Dependent's First Name						_												
		,	/															
5. Other Dependent's First Name						_												
			/															
6. Other Dependent's First Name																		
			, ,															

Please enclose additional family member information on a separate piece of paper.

**Acknowledgement:** WellDyneRx will substitute FDA approved generic equivalent drugs for any brand name medication(s) ordered unless specified by the prescriber or me on each prescription. I will take personal responsibility for payment of all medications that I or my family members receive.

Remember to write your Member I.D., Date of Birth, Brand/Generic preference and Fill Now or Hold on each prescription sent in.

If "Profile" or "Hold" is not written on the front of your prescription, your medication will be filled immediately.

Signature	Date_
	Enclose with prescription(s)

# WELLDYNERX WILL CONTACT YOUR PRESCRIBER FOR NEW PRESCRIPTIONS

Complete this section only if requesting new mail order prescription(s) from your prescriber. We substitute generics on prescriptions unless otherwise noted by your prescriber.

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Patient Name	Date of Birth	Medication Name and Strength	Prescriber's Name, Phone Number and Fax Number

Once WellDyneRx has received all necessary and correct information, orders will ship within 2 to 3 business days.