Call your doc	tor for medical advi	ce about side effects.	You may rep	ort side effects to FDA at 1-80)0-FDA-1088.
• TAetn	Ord	scription ler Form	Ques	tions? Call 1-800-227-5720 to	p speak to a pharmacist
Member ID: Date of Birth:	Review the Ir	1. Onli 2. By I 3. By I 4. By I	ne V Phone C (Mail F p Fax Y	(isit www.aetna.com/aetna.call us at 1-800-227-5720 for hearing impaired) at 1 fill out the information and rescription(s) and this Order Four physician may fax you completed forms to: 1-866 only sician may fax a prescription in the completed forms to: 1-866 only sician may fax a prescription.	arxhomedelivery or TDD -800-823-6373. d send your refill slips form to the address below our prescription(s) and
Please write in of prescription submitting with New	n(s) you are	,	Aetna Rx PO Box 82 Pembroke	Home Delivery	
SECTION 2		rdholder Informa as changed or does no	using tion	Il information clearly as s BLUE or BLACK ink: 1	-
Member ID Last Name Address 1		E-n	First	Name Number	MI
Address 2 City SECTION 3	Comments F	Relating to This O	State	nate Phone Number Zip Code	
•	ll in oval for Expe (\$20 additional c	harge)		Actno Dy Homo Doliv	AONA DO NOT
O Check or Money Order		eck or money order particlesed (excluding cr		Aetna Rx Home Delivayment): \$,	very DO NOT SEND CASH
O VISA	Obiscover	0 - 1/4 0			
MactorCard	∧ American Evr	credit Card	J #		Exp Date

Exp Date MasterCard American Express Use for this transaction only Use Credit Card on File Cardholder Signature I authorize Aetna Rx Home Delivery to bill my credit card. I understand that my credit card will be billed the following amounts

in effect at the time my order is filled: any applicable copayment(s), coinsurance and/or deductible(s), payments due for any medications not covered under my benefit plan, plus any special shipping costs. I also understand my credit card will be charged for future orders, unless I provide an alternative form of payment or indicate otherwise by selecting "Use for this transaction only" above.



				WE WILL DISPENSE FDA-APPROVED GENERIC-EQUIVALENT MEDICATION WHEN AVAILABLE AND APPROPRIATE AS INDICATED ON YOUR PRESCRIPTION.						
SECTION 5 New Prescription (Order			INDIC	CATED ON TOO	X FIXESCKIF	TION.			
Fill out the information below and enclose nev	w prescri	iption(s) and	payment with t	this form					
Patient First Name	Self O	Out	LL LL	MM/D	D/YYYY	Doctor Pho	one Number			
	Spouse	Dependent	Sex M / F							
Doctor Last Name		٥	0)	Drug Name						
Patient First Name	Self O	ent 🔾	_ F	MM/D Date of Birth	D/YYYY h	Doctor Pho	one Number			
Doctor Last Name	Spouse	Dependent	Sex M / F	Drug Name						
Patient First Name	Self O	O to		MM/DI Date of Birth	D/YYYY	Doctor Pho	Done Number			
Doctor Last Name	Spouse	Dependent	Sex M / F	Drug Name						
SECTION 6 Refills - Please send in refill slips for medications you would like to order. If you do not have your refill slip please complete the section below.										
Print Prescription Number Here			Print Prescription Number Here							
Print Prescription Numbe	r Here				Print Prescrip	tion Numbe	r Here			
Drug Name:				Dr	Print Prescrip					
				Dr						
Drug Name:	r Here				rug Name:	tion Numbe	r Here			
Drug Name: Print Prescription Numbe Drug Name:	r Here				rug Name:	tion Numbe	r Here			
Drug Name: Print Prescription Numbe	r Here		s —		rug Name:	tion Numbe	r Here			
Drug Name: Print Prescription Numbe Drug Name:	r Here Condi	tions	stome	Dr	rug Name:	tion Numbe	r Here Health Conditions			
Print Prescription Numbe Print Prescription Numbe Drug Name: Allergies & Health Complete this section only if addir or there are changes to exist	r Here Conding a new ing custoditions important the conditions in	tions w cus stome	stome er dicate:	Dr er s no nange	rug Name:	mycin S ies (woled in below)	r Here			

known allergies. For existing customers, this indicates no change from information provided to Aetna Rx Home Delivery previously.

| MM / DD / Y Y Y Y Y | Dependent's First Name | Date of Birth | Date of Bi

Please write the person's name and list their Other Allergies and/or Health Conditions referenced above:

Please Note: By submitting this form you verify that the information is correct, that the prescriptions enclosed are for use by eligible participants and authorize the release of all information to the Plan Sponsor, administrator, or underwriter. All communications regarding this account will be directed to the member (employee/retired). If a spouse or other eligible dependent wishes to direct their communications to an alternate address or telephone number, they may make this request by completing the Confidential Communications Request form provided in the Privacy Notice, or as available on our website.

