



As a member of Blue Cross Blue Shield of Massachusetts, you can buy certain medications at the Express Scripts<sup>®</sup> mail service pharmacy. It's a great way to save by purchasing prescriptions on a long-term basis.

## Check Out These Benefits!

**Savings** The biggest advantage of the mail service pharmacy is that for most long-term maintenance medications you can order up to a 90-day supply. Often times, using mail service results in the lowest possible out-of-pocket costs to you as a member.

**Convenience** Your medications will be delivered to your home, postage paid, within 14 days of mailing your new prescription.

**Confidentiality** If you have questions, you can call Express Scripts toll-free, 24 hours a day. Registered pharmacists are available to answer your questions about your prescriptions confidentially. Call **1-800-892-5119**.

**Special-Needs Services Available** For the convenience of our hearing-impaired members, Express Scripts is TTY-ready, and has installed a separate toll-free number for you to use with your TTY equipment. The number is **1-800-305-5376**.

For our vision-impaired members, upon special request with your order, Express Scripts can provide Braille labels for your medication.

And for our non-English-speaking members, Express Scripts can provide translation services when you call the toll-free line.

Refer to your benefit literature for specific coverage information.

## Three Easy Steps To Use Mail Service

For long-term prescriptions, use our mail service pharmacy to save.

1. Ask your doctor to prescribe medications for up to a 90-day supply, plus refills when applicable. (If you're already taking medication on a long-term basis, ask your doctor for a new prescription.)
2. Complete the attached Mail Order Form for each member submitting a prescription. Be sure to answer all of the questions.
3. Seal the form, prescriptions, and the appropriate copayment in the pocket in this brochure (do not send cash). Then simply mail it in. Be sure to write your ID number exactly as it appears on your ID card.

Your order will be quickly processed and sent to you by mail or UPS. Allow 14 days for delivery from the date you mail the order. To prevent delays, do not fill medications that are needed quickly or short-term medications (e.g. antibiotics) via mail service.

## Confidential Subscriber/Patient Profile

Please write your ID number, name, and address on the attached form. Then complete the Patient Profile for you and each of your dependents submitting prescriptions, indicating any drug allergies, and health conditions. Express Scripts will use this information to check any potential drug interactions when you have prescriptions filled. If there are no drug allergies, please check "None" in the box provided.

## Instructions

### New Prescriptions:

- Have your doctor/provider write the prescription for up to a 90-day supply
- To prevent any delays, make sure that an approved formulary exception (if applicable) for any medications that are non-covered or require prior authorization is on file before you place your order
- Complete all information requested on the attached Mail Order Form
- Select your preference for Safety Caps in the appropriate box
- Ensure that the patient's full name, age, ID number, and address appear on each prescription
- Find out the appropriate copayment necessary for the medication prescribed
- Place prescriptions and copayments in return envelope and mail

### Refills:

- Call **1-800-892-5119** or visit **www.express-scripts.com** to refill your order, or
- Place refill slips and copayments in the return envelope and mail it

Make all checks or money orders payable to "Express Scripts". Do not send cash. If paying by credit card, complete the information under "Credit Card Information."

**PLEASE PRINT CLEARLY**



## Answers to Your Questions

### How Do I Determine What Copayment Amount I Should Include With My Order?

Check your benefit literature, and if you still have specific questions, call the Blue Cross Blue Shield of Massachusetts Member Service phone number listed on the front of your ID card.

### Why Did My Order Contain Generic Drugs When My Prescription Requested a Brand-Name Version?

When authorized by your doctor and permitted by applicable law, Express Scripts will dispense a generic drug. This usually saves you money, so whenever possible, ask your doctor to prescribe generic drugs.

### Why Isn't My Drug Available Through the ESI Mail Service?

Certain medications that require immediate administration and/or are used for short periods of time are inappropriate for mail service. In addition, for certain medications classified as specialty drugs, Blue Cross Blue Shield of Massachusetts has established a relationship with a preferred specialty pharmacy. They offer additional services that are not offered by our mail service pharmacy.

### How Do I Order Refills?

Simply call the toll-free number, **1-800-892-5119**, and order your refills over the phone. You can also visit the Express Scripts website to refill your order ([www.express-scripts.com](http://www.express-scripts.com)). Once you have ordered through mail service, you will receive a refill slip with your prescription.

Enclose the slip and the appropriate copayment amount in the order envelope (which is provided).

### What Do I Do in Emergency Situations?

When you need medication immediately, simply have your prescription filled at a local pharmacy. If you need medication immediately, but will be taking it on an ongoing basis, you can ask your doctor to write two prescriptions:

- You can fill the first prescription at a local participating pharmacy;

- Send the second prescription (up to a 90-day supply), along with your copayment, to Express Scripts immediately.

## About Your Prescription

Blue Cross Blue Shield of Massachusetts maintains a list of covered prescription drugs. If you have any questions about whether or not your medications are covered, or subject to Quality Care Dosing, Step Therapy, or Prior Authorization, please visit [www.bluecrossma.com/pharmacy](http://www.bluecrossma.com/pharmacy) or call the Blue Cross Blue Shield of Massachusetts Member Service number on the front of your ID card.

## Mail Service Questions

Call Express Scripts customer service 24 hours a day, 7 days a week. Pharmacy consultation is also available around-the-clock.

**Toll-Free Number: 1-800-892-5119**  
(TTY: 1-800-305-5376)

### *Please Note:*

Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations and to the professional judgment of the pharmacist. If you have any questions regarding your medication, please call Express Scripts customer service at **1-800-892-5119**.

It's the patient's responsibility to report to Express Scripts any changes in drug allergies, health conditions, chronic diseases, and drug sensitivities.

Prescription information about members and dependents is used by Express Scripts to administer your prescription program. As part of the administration, Express Scripts reports that information to Blue Cross Blue Shield of Massachusetts. Express Scripts also uses the information and prescription data gathered from claims submitted nationwide for reporting and analysis, without identifying individual patients in accordance with applicable laws.



MASSACHUSETTS



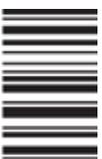
This Plan is administered by Blue Cross and Blue Shield of Massachusetts, Inc. © Registered Marks of the Blue Cross and Blue Shield Association and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. ® Registered Marks of Express Scripts, Inc. © 2011 Blue Cross and Blue Shield of Massachusetts, Inc. #109265M 32-7040 (12/11) 200M

# Your Mail Service Pharmacy Benefit



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association



1042

### Patient 1 (Cardholder)

Name: \_\_\_\_\_

I want non-child resistant caps, when available.

Date of Birth (MM/DD/YYYY)

□ / □ / □ □ □ □

### Patient 2

Name: \_\_\_\_\_

I want non-child resistant caps, when available.

Date of Birth (MM/DD/YYYY)

□ / □ / □ □ □ □

#### Date of Birth is required for patient identification.

Failure to provide complete and accurate information may prevent the pharmacy from detecting drug related problems.

OTHER	DEVICES	OTC	HEALTH CONDITIONS	DRUG ALLERGIES	No Other Prescriptions	List other Prescription Medications here:		
<p><input type="radio"/> List other Prescription Medications here:</p>	<p><input type="radio"/> List Medical Devices here:</p>	<p><input type="radio"/> List other OTC that you take on a regular basis:</p>	<p><input type="radio"/> List other Health Conditions here:</p>	<p><input type="radio"/> List other Allergies here:</p> <p><b>No Known Allergies</b></p> <p>Acetaminophen/Tylenol® Amoxicillin Aspirin Cephalosporin (i.e., Keflex®, Cephalexin) Codeine Erythromycin, Biaxin®, Zithromax® NSAIDs (i.e., Ibuprofen, Naproxen) Oxycodone (i.e., OxyContin®, Percocet®) Penicillin Sulfa Tetracycline (i.e., Doxycycline, Minocycline)</p> <p><b>No Known Health Conditions</b></p> <p>Arthritis (715.9) Asthma (493.9) Chronic Bronchitis or Emphysema (496) Depression (311) Diabetes Type I (250.01) Diabetes Type II (250.00) Epilepsy/Seizures (345.9) GERD (530.81) Glaucoma (365.9) High Cholesterol (272.9) Hormone Replacement Therapy (627.9) Hypertension (401.9) Thyroid: Low (244.9)</p> <p><b>No Over-the-Counter Medications</b></p> <p>Acetaminophen/Tylenol® Advil®/Aleve®/Motrin® Aspirin/Excedrin®</p>	<p><input type="radio"/> List other Health Conditions here:</p>	<p><input type="radio"/> List Medical Devices here:</p>	<p><input type="radio"/> List other OTC that you take on a regular basis:</p>	<p><input type="radio"/> List other Prescription Medications here:</p>
<p>Prescription Medications not filled through Express Scripts Pharmacy.</p>	<p>Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.</p>	<p>No Medical Devices</p>	<p>No Other Prescriptions</p>	<p>No Known Allergies</p>	<p>No Medical Devices</p>	<p>List other OTC that you take on a regular basis:</p>	<p>List other Prescription Medications here:</p>	

FDA approved generic medications will be dispensed when allowed by your doctor, subject to the terms outlined in your plan. I certify that all the information on this form is correct. I permit Express Scripts Inc. to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment or health care operations.

Signature Required

More than two family members on your plan? On a separate sheet of paper, write the family member(s) name, date of birth, allergies and health conditions along with the name and phone number of their doctor/prescriber.

Please Note: Your order may be filled at any one of our Express Scripts Pharmacies located nationwide.

**REMINDER: This section must be removed before mailing.**

## Express Scripts Pharmacy Prescription Order Form

▶ **To order online:** sign in at [www.StartHomeDelivery.com](http://www.StartHomeDelivery.com) and follow the prompts. ◀

**To order by mail:** complete this form and ask your doctor to write your prescription for a 90-day supply or the maximum days supply allowed by your plan.

- Use ALL CAPITAL LETTERS in BLACK INK. Fill in the ovals (●).
- Remember to mail your prescription with this completed form. Your medication will arrive within two weeks from the date we receive your first order.

**NOTE:** Standard shipping is *FREE* for online and mail orders.



1041

ID Card Number

First Name

MI

Date of Birth (MM/DD/YYYY)

Last Name

Gender

M ● F

Some medications cannot be delivered to a PO Box. Provide a street address to allow delivery of your order.

Shipping Address 1

Shipping Address 2

City

State

Zip Code

Check here for rush shipment. Your order, once received and filled, will be shipped overnight for \$21.

Email

Please select one as your preferred telephone number

Daytime Phone

Evening Phone

Cell Phone

Doctor/Prescriber Last Name

Doctor/Prescriber Phone Number

First Name

MI

Date of Birth (MM/DD/YYYY)

Last Name

Gender

M ● F

Email

Doctor/Prescriber Last Name

Doctor/Prescriber Phone Number

All individuals included in the family will be charged to this credit card.

● Apply to this order only

● Apply to all orders

Amount Enclosed

● Check Card

● Credit Card

● Check / Money Order

\$

Card #

Exp. Date (MM/YY)

Sign here to authorize card payment X

PATIENT 1 (CARDHOLDER)

PATIENT 2

PAYMENT

Detach Here

For all orders after 08/01/2011, use this form. Fold and tear off this piece before putting in the return envelope.

Detach Here

MLRBE/MP



Four horizontal lines for recipient information.

NO POSTAGE  
NECESSARY  
IF MAILED  
IN THE  
UNITED STATES

**BUSINESS REPLY MAIL**  
FIRST-CLASS MAIL PERMIT NO. 3580 ST LOUIS MO

POSTAGE WILL BE PAID BY ADDRESSEE

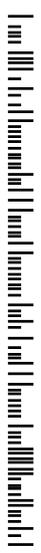
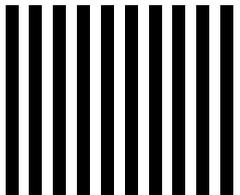


EXPRESS SCRIPTS®

Home Delivery Service

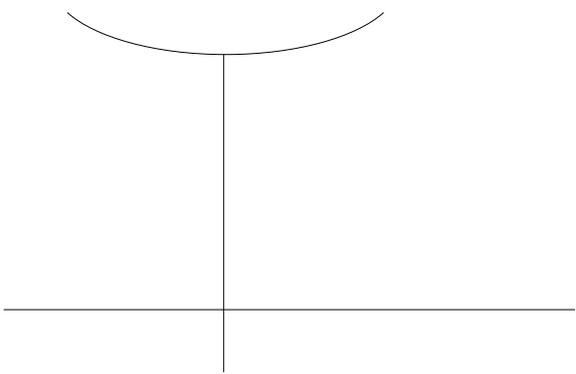
PO Box 66566

St Louis, MO 63166-9967



Thank you for using our mail service prescription drug program.

Please note that all prescriptions requiring a formulary exception will not be processed without prior approval. To prevent any delays, make sure that an approved formulary exception (if applicable) is on file before you place your order.



## Did You Remember To...

- Complete all applicable information
- Include your ID number on the mail order form
- Enclose the original prescription, mail order form, and appropriate copayment
- Make checks or money orders payable to “Express Scripts”, or include credit card information