Prescription Mail Order Form

This Mail Service Enrollment Form is **only** necessary for:

- first time orders, including dependents who have been added since the last order, or
- changing current information.

To start your Mail Service Benefit, follow these steps:

Step 1: *Enroll*
Complete the mail order enrollment form.

Step 2: *Fill Your Prescription*
Mail the original prescription to NoviXus with your enrollment form, or have your health care provider send the prescription directly to NoviXus. Your provider can send the prescription to NoviXus through the following options:

- Provider E-prescribes to NoviXus
- Provider Faxes: 1-877-395-4836
- Provider Calls: 1-877-269-1159
- Patient Mails Paper Prescription: PO Box 8004, Novi, MI 48376-8004

Step 3: *Complete Payment*
Make your copayment by phone at 1-877-668-4987 or by mail. NoviXus accepts major credit cards and checks.

How to Order Refills:

Online www.Novixus.com
Phone 1-877-668-4987 (24 hour automated phone line)

Refill orders should be placed two weeks prior to when the medication will be needed.

NoviXus will fill your order with an FDA-approved equivalent generic, unless otherwise indicated by your prescriber. FDA-approved generic drugs contain the same active ingredients and come in the same dosage forms as their brand-name counterparts, and must meet comparable safety, production and performance standards.

Your prescription order will be shipped using US Mail. Some items may be shipped by expedited courier. Refrigerated items are shipped in accordance with FDA and manufacturers' specifications. For your security, some controlled substances may require a signature at delivery.

Prescriptions cannot legally be mailed from a mail order pharmacy (or any other pharmacy operating within the United States) to locations outside of the United States.

Prescription Mail Order Form

Please complete and mail this form with all prescriptions. Please print or type. Please list all insurance applicable.

Subscriber Information

Last Name First Name M.I. Date of Birth

Home Address City State ZIP

Shipping/Billing Address* City State ZIP

*If Shipping and Billing Addresses are different, please provide both addresses.

Primary Phone Secondary Phone

E-mail Address

Group Name (Primary) Group ID# Member ID#

Group Name (Secondary) Group ID# Member ID#

----------BILLING INFORMATION----------

Check Enclosed: ☐

Please Charge My: ☐ Visa ☐ Master Card ☐ Discover ☐ American Express

Credit Card * Number

Expiration Date MM/DD/YYYY

Cardholder's Name

Signature

***Credit Card Will Be Used For All Future Orders**

Acknowledgement: I understand that when permitted by law, NoviXus will substitute an FDA approved generic equivalent drug for any brand-name medications enclosed with this order unless specified by the Plan or prohibited by me or the prescriber in writing. For all prescriptions submitted, I certify that I or my family members are eligible to receive prescriptions under this plan. I will take personal responsibility for payment of all medications that I or my family members receive.

Member Information					**Drug Allergies** ** Please enclose additional family member information, such as drug allergies, on another piece of paper.								
Family Member Name	ID Number	Date of Birth	Relationship to	Gender M/F	None	Ampicillin	Aspirin	Codeine	Erythromycin	Penicillin	Sulfa	Tetracycline's	Other** Please Specify

Once NoviXus has received all necessary and correct information, please allow 2 weeks for prescription order delivery.

Mail completed form to:

NoviXus

P.O Box 8004

Novi, Michigan 48376-8004

X_____

Member signature