

*For any questions call us at 1-800-687-8629*

### **(1) PATIENT INFORMATION**

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

E-mail Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

Phone: 

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City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

D.O.B.: 

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Cardholder ID: \_\_\_\_\_

Group ID: \_\_\_\_\_

We will keep this address on file for all orders filled on this account until another address is provided.

**For address changes, please call  
VytOne Pharmacy at (800) 687-8629.**

Sex:  Male  Female

Relationship to Cardholder:

Self  Spouse  Child

### **(2) DRUG ALLERGIES & CHRONIC ILLNESSES**

Drug Allergies:  None  Codeine  Sulfa  Aspirin  Penicillin  Other \_\_\_\_\_

Severity of Drug Allergies:  Mild  Moderate  Severe  Intolerance  Anaphylaxis

List your over-the-counter medications:

Chronic Illnesses:  Thyroid  High Blood Pressure  Diabetes  Glaucoma  
 (Disease States)  Heart Condition  Intestinal Disorders  Lung Condition  Other \_\_\_\_\_

### **(3) GENERIC MEDICATION INFORMATION**

In accordance with Texas Pharmacy Law and availability, VytOne Pharmacy will always dispense a generic medication with a lower co-payment unless you specify otherwise. Please contact a member advocate at (800) 687-8629 to advise us of medications that you want dispensed brand-name only or use the space provided on the reverse side of this form to notify us of brand-name only medication exceptions.

<sup>1</sup>Please refer to the reverse side of this form for further details.

### **(4) PAYMENT METHOD**

In order to process your prescriptions quickly, please enclose the correct co-payment amount(s). If assistance is needed with calculating co-payment amount(s), please call VytOne at (800) 687-0707.

Payment Options:  Check/Money Order  Credit Card

#### **Paying By Credit Card?**

Visa

MasterCard

Discover

American Express

Credit Card Number:

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Expiration Date:

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 MM/YYYY

Check here to decline keeping credit card information on file at the pharmacy.

Credit card already on file.

X \_\_\_\_\_  
 Signature of Cardholder

**Use reverse side for prescription refills.**

## (5) ORDER REFILLS

### Brand-Name Only Medication Exceptions:

Rx Number	Name of Medication	Strength	Doctor's Name	Co-payment

### Order Refill Prescriptions Here:

Rx Number	Name of Medication	Strength	Doctor's Name	Co-payment

**Expedited Shipping via UPS or FedEx:**  **\$25.00 for overnight shipping**  **\$15.00 for 2-day shipping**  
 **\$35.00 for Saturday Delivery (if available in your area)**

Note: Expedited shipping will **not** rush prescription processing. Prices subject to change.

## (6) HOW TO ORDER

### HOW TO ORDER REFILLS:

**BY MAIL:** Complete the payment and refill sections, and mail to VytlOne Pharmacy.

**BY PHONE:** Call us toll free at (800) 687-8629 and use our automated system to enter the Rx number printed on your prescription label, or speak to a member advocate during normal business hours.

**BY INTERNET:** You may refill your prescriptions by visiting [www.VytlOneMembers.com](http://www.VytlOneMembers.com). Log in or create a Member Portal account, then select the PHARMACY REFILLS tile. You will need your prescription number(s) and credit card information available.

### HOW TO ORDER NEW PRESCRIPTIONS:

**BY MAIL:** Complete the payment and patient information sections, enclose your new prescriptions, and mail to VytlOne Pharmacy.

**BY PHONE:** Have your doctor call in new prescriptions to (800) 687-8629

**BY FAX or ELECTRONIC PRESCRIBING:** Your doctor can fax or escribe new prescriptions to (866) 589-7656. In accordance with Texas law, only your doctor can fax new prescriptions.

## (7) IMPORTANT INFORMATION

1 The submission of this form, for you or any of your dependents, authorizes the release of all information to the Plan Sponsor, Administrator, or Underwriter, and authorizes the prescription to be filled with the generic equivalent when available and permissible by law, in accordance with your benefit plan requirements. If you request a brand name drug when your doctor permits substitution, you may be responsible for paying the difference in cost between the brand name drug and the generic equivalent plus a co-payment. Refer to your plan benefit information for more details or contact a member advocate at (800) 687-8629.

**Reminder:** You will always be charged the mail order co-pay when you send or transfer a prescription to VytlOne Pharmacy. To maximize your savings, ask your doctor for a 90 day supply with refills up to one year.

Written information about this prescription has been provided for you. Please read this information before you take this medication. If you have questions concerning this prescription, a pharmacist is available during normal business hours to answer your questions. Please call your pharmacy.

Complaints against the practice of pharmacy may be filed with the:

Texas State Board of Pharmacy  
1801 Congress Avenue  
Suite 13.100  
Austin, Texas 78701-1319 • (512) 305-8000  
To receive a complaint form call  
(800) 821-3205 or (512) 305-8080 if in Austin.  
(recorded information only)  
[www.tsbp.state.tx.us](http://www.tsbp.state.tx.us)

Se la presentado a usted la informacion por escrito sobre esta receta. Favor de leer esta informacion antes de tomar el medicamento. Si usted tiene preguntas tocante a esta receta, estara un farmaceutico disponible durante las horas de negocio para contestar sus preguntas. Por favor llame a su farmacia.

Quejas contra la practica de la farmacia pueden ser reportadas al:

Concilio de Farmacia Del Estado De Texas  
1801 Congress Avenue  
Suite 13.100  
Austin, Texas 78701-1319 • (512) 305-8000  
Para recibir una forma de queja llame:  
(800) 821-3205 or (512) 305-8080 if in Austin.  
(informacion grabada solamente)  
[www.tsbp.state.tx.us](http://www.tsbp.state.tx.us)