

Providing You Convenience,
Quality and Savings

Our Mission

We are dedicated to providing the most convenient, highest quality, and safest mail service pharmacy solution in the friendliest and most cost-effective manner. Our standard of performance is 100 percent quality and 100 percent satisfaction, 100 percent of the time.

What is the Mail Service Pharmacy Program?

The Mail Service Pharmacy Program is an extension of your pharmacy benefit that offers additional advantages for people taking medication to treat ongoing health conditions. The program provides up to a 90-day supply of maintenance medication, including refills, that are mailed directly in a confidential and secure manner.

Advantages include:

- **Convenience** – Medications are mailed to your home at NO ADDITIONAL COST. Orders are mailed promptly and shipped in confidential, protective packaging.
- **Quality** - Registered pharmacists dispense and validate each order.
- **Safety** – Potential drug allergies and interactions are checked against your comprehensive health profile on record.
- **Save Time** – Your 90-day supply of medication will help you avoid unnecessary trips to a retail pharmacy.
- **Save Money** – A single copayment for a 90-day supply of medication using the mail service pharmacy typically costs less than multiple copayments of the same quantity of medication dispensed at a retail pharmacy. Check with your plan for more details.
- **Toll-Free Customer Service** – A national toll-free number is available to assist you.
- **Tax Receipts Provided** – Tax and insurance receipts are included with every order.

Welcome to Your Mail Service Pharmacy Program

OhioDAS



Toll-Free: 1-866-854-8850

Fax: 1-800-893-2299

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How do I start using the Mail Service Pharmacy Program?

- If you are currently taking a medication to treat an ongoing health condition, ask your physician to write two prescriptions, one for a sufficient supply of medication to be filled at a local pharmacy to cover your immediate needs AND one for a 90-day supply with refills (up to one year, if appropriate) to begin using the mail service pharmacy.
 - If you are taking a brand-name drug, ask your physician about generic alternatives so that you can receive the most value from your pharmacy benefit.
- Complete the confidential *Registration and Prescription Order Form* and include it with your first order only. This will establish your comprehensive health profile so we can better serve you.
- Write your member identification (ID) number on the back of each prescription.
- Include your copayment or co-insurance amount. Accepted forms of payment include major credit cards (*Visa, MasterCard or Discover*), check and money order. Please do not send cash.
- Refer to the telephone number on your member ID card if you have any questions about payment.
- Mail your prescription(s) and completed *Registration and Prescription Order Form* to Immediate Pharmaceutical Services, Inc. (IPS) using the self-addressed postage-paid envelope provided.
- Your order will be processed within 48 hours after receipt and will be mailed directly to you via UPS or U.S. Mail along with reorder instructions and return envelopes.

What about generic vs. brand-name drugs?

The generic name of a drug is its chemical name and the brand-name is the trade name under which the drug is advertised and sold. By law, generic and brand-name drugs must meet the same standards for safety, purity, strength and effectiveness. When authorized by your physician and permitted by applicable law, the pharmacy is able to dispense a generic drug when available. Only generic drugs rated highest by the U.S. Food and Drug Administration will be used to fill your order. This reduces your out-of-pocket cost without compromising quality or effectiveness. If you are taking a brand-name medication, ask your physician if a generic alternative is right for you.

How do I order refills?

- **Online** - Order your refills for existing prescriptions at www.catalystrx.com via the "Mail Service" link.
- **Telephone** - You may also order refills through the automated touch-tone refill service by calling **1-866-854-8850**.
- **Mail** - Complete the reorder form included with your original prescription order and return it using the self-addressed envelope provided.

Please note that your prescription label and customer receipt will indicate the number of times you may refill the current prescription.

When should I order my refills?

Please remember to reorder your medications at least 14 days before your supply runs out to allow for processing and delivery of your order.

Five Quick Steps to Get Started

1. **Ask your physician to prescribe up to a 90-day supply of maintenance medications, plus refills.**
2. **Complete the *Registration and Prescription Order Form*.**
3. **Enclose your physician's written prescription(s).**
4. **Include your copayment or co-insurance amount, and/or credit card information.**
5. **Enclose items 2, 3 & 4 and return them in the self-addressed postage-paid envelope provided.**



Registration and Prescription Order Form

33381 Walker Road • P.O. Box 166 • Avon Lake, OH 44012-9927
Telephone: 1-866-854-8850 • Fax: 1-800-893-2299

Please complete this form and return it, along with your prescriptions, to:
Immediate Pharmaceutical Services, Inc., P.O. Box 166, Avon Lake, Ohio 44012-9927.
Your order will be processed within 48 hours after receipt and will be mailed via UPS or U.S. Mail.

Member Information

Male/Female:	Date of Birth:	Member ID Number (located on card):
Suffix (if on card):	Group Number:	
Employer Name:		
Last Name:		First Name:
Daytime Telephone:	Evening Telephone:	
E-mail Address (to receive information regarding the processing of your order):		
Permanent Address 1:		
Permanent Address 2:		
City, State & ZIP:		

Other Dependents Eligible for the Program (Please print)

Spouse	First _____	MI _____	Last _____	DOB _____	Sex _____
Dependent 1	First _____	MI _____	Last _____	DOB _____	Sex _____
Dependent 2	First _____	MI _____	Last _____	DOB _____	Sex _____
Dependent 3	First _____	MI _____	Last _____	DOB _____	Sex _____

Please Complete the Following Health Profile for Yourself and Each Eligible Dependent

Allergies	Member	Spouse	Dependent 1	Dependent 2	Dependent 3	Health Conditions	Member	Spouse	Dependent 1	Dependent 2	Dependent 3
Aspirin	<input type="radio"/>	Asthma	<input type="radio"/>								
Cephalosporins	<input type="radio"/>	Diabetes	<input type="radio"/>								
Codeine derivatives	<input type="radio"/>	Glaucoma	<input type="radio"/>								
Morphine derivatives	<input type="radio"/>	Heart Disease	<input type="radio"/>								
Penicillin	<input type="radio"/>	Hypertension	<input type="radio"/>								
Sulfa drugs	<input type="radio"/>	Thyroid Disease	<input type="radio"/>								
Erythromycin	<input type="radio"/>	Seizure Disorder	<input type="radio"/>								
None known	<input type="radio"/>	Ulcers	<input type="radio"/>								
						None known	<input type="radio"/>				
Other Allergies:						Other Health Conditions:					
Member _____						Member _____					
Spouse _____						Spouse _____					
Dependent 1 _____						Dependent 1 _____					
Dependent 2 _____						Dependent 2 _____					
Dependent 3 _____						Dependent 3 _____					

If a dependent's prescription needs to be delivered to a different address, please submit information on a separate sheet of paper or call 1-866-854-8850. I have attached additional address information.



PRESCRIPTION FAX FORM

33381 Walker Road • PO Box 166 • Avon Lake, Ohio 44012

FORM INSTRUCTIONS

PATIENT INSTRUCTIONS: In all cases, you should try to obtain a new written prescription from your physician and mail it to Immediate Pharmaceutical Services, Inc. (IPS) along with the *IPS Registration and Prescription Order Form*. If this is not possible, follow these steps to have your physician submit your prescription directly via fax:

1. Complete the sections below using black ink only
2. Have your physician fill out the prescription information
3. Have your physician fax the completed form to IPS at 1-800-893-2299
4. Allow two weeks for delivery

NOTE: This form must be faxed directly from your physician's office in order to be valid.

Please ensure you have a credit card on file for payment of your order. By having your physician submit this form, you are authorizing IPS to charge your credit card. If you are unsure of the copayment for the following prescription, you may obtain prescription copayment information in advance by calling 1-866-854-8850.

Physician Name: _____

Faxed By: _____

Physician Telephone #: _____

Physician Fax #: _____

IPS Telephone: 1-866-854-8850

IPS Fax: 1-800-893-2299

By providing this form, you have authorized release of all information to IPS, as needed, to process your prescription and refills.

PRESCRIPTION INFORMATION

Physician Name: _____

Office Telephone: _____

Patient Name: _____

Patient Telephone: _____

Member ID #: _____

Patient DOB: _____

This section is to be completed by the prescriber.

Medication Name: _____ Strength: _____

Quantity: _____

Directions: _____

Refills: _____

MD Signature: _____

DEA Number: _____ Date: _____

PHYSICIAN INSTRUCTIONS: Please FAX completed form back to IPS.

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.