Home Delivery Order Form

1 Member and physician information. Please use black or blue ink. One form per member.

Member ID Number			Gender ☐ M ☐ F
Last Name	First Name		MI
Delivery Address			Apt. #
City	State	ZIP	
Date of Birth / /	Email		
Physician Name	Physician Phone Number ( )		

Phone Number (list in order of preference) (circle one)

(_____)_____ M H W

(_____)_____ M H W

(_____)_____ M H W

Best time to be reached: AM PM

2 Health history

Medication Allergies:

☐ Amoxil/Ampicillin ☐ Erythromycin ☐ None Known
☐ Aspirin ☐ NSAIDs ☐ Sulfa
☐ Cephalosporins ☐ Penicillin ☐ Tetracyclines
☐ Codeine ☐ Quinolones ☐ Others: _____

Health Conditions:

☐ Arthritis ☐ Glaucoma ☐ None Known
☐ Asthma ☐ Heart Condition ☐ Osteoporosis
☐ Cancer ☐ High Blood Pressure ☐ Thyroid Disease
☐ Diabetes ☐ High Cholesterol ☐ Others: _____

List all prescription, over-the-counter and herbal medications taken regularly: (use additional sheet if necessary)

3 Refills. To order home delivery refills, enter your prescription number(s):

1: _____ 2: _____ 3: _____ 4: _____

5: _____ 6: _____ 7: _____ 8: _____

4 Pharmacy processing

Generic substitution: FDA-approved generic equivalents will be dispensed for brand-name drugs whenever possible, unless you or your physician indicate otherwise. Brand-name medications may be subject to a higher cost. Generic equivalents are usually less expensive than brand name drugs. If we dispense a brand name drug, you may be responsible for a higher copayment and/or the difference between the brand and generic price of each drug. If allowed by your prescriber, we will dispense a generic equivalent unless you check this box. ☐ I do not accept a generic equivalent.

Keep on file: If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them here:

Notes to Pharmacy:

5 Payment and shipping information — do not send cash.

Standard delivery is included at no charge. Most prescription orders arrive within 7 days from the date your order is received. We will contact you if there is an extended delay in delivering your medications. Please call 800.424.8274 if you have any questions. Once shipped, medications may not be returned for a refund or adjustment. Visit www.magellanrx.com to download additional order forms.

☐ Ship overnight. (additional charges will apply). Please call to verify pricing. No P.O. BOX overnight shipping.

☐ Check enclosed. All checks must be signed and made payable to: Magellan Rx Pharmacy.

☐ Charge to my NEW credit card.

☐ Charge to my credit card on file.

I authorize Magellan Rx to charge the following amount to my credit/debit card without prior notification:

____up to $150 ____up to $250 ____up to $_____ (other amount greater than $250)

For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance, and other such expenses related to prescription orders. By supplying my credit card number, I authorize Magellan Rx Management to maintain my credit card on file as payment method for any future charges. To modify payment selection, Customer Service can be contacted at any time.

Cardholder Signature:	Date:

Credit card number (VISA®, MasterCard®, Discover®, or American Express®are accepted.) and expiration date (month/year)

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐ / ☐☐☐☐

6 Complete your order form

Mail this completed order form with your new prescription(s) to Magellan Rx Pharmacy, P.O. Box 620968, Orlando, FL 32862. DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.

Magellan Rx MANAGEMENT℠