MAIL SERVICE ORDER FORM

Mail order form to:

<table>
<thead>
<tr>
<th>CAREMARK</th>
<th>MTP-STD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO BOX 94467</td>
<td>PALATINE, IL 60094-4467</td>
</tr>
</tbody>
</table>

Enter ID # below if not shown or if different from above

Add the following information to the order form:
- Last Name
- First Name
- MI
- Suffix (JR, SR)
- Apt./Suite#
- City
- State
- Zip Code
- Daytime Phone#
- Evening Phone#
- Refill Order Continuation Form
- Caremark Refill Label
- Prescription Number

Shipping Information (Complete ONLY IF DIFFERENT or not shown above)

Use this form to order NEW and/or REFILL mail service prescriptions. Please print in BLUE or BLACK INK using CAPITAL letters only. FOR FASTEST SERVICE: Order refills and verify benefit information at www.caremark.com or call toll-free 1-800-824-6349

Visit www.caremark.com for the fastest refills. Log in to check order status and access personalized information about your prescription benefits. IMPORTANT NOTICE: When getting a new prescription, be sure to ask your doctor to write your prescription for the maximum amount allowed by your benefit plan, usually a 90-day supply. Make sure your doctor SIGNS and DATES all new prescriptions.

Unless otherwise directed, all prescriptions received on a single order form or in a single envelope may be shipped together in one package.

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Fill in for individuals receiving a prescription with this order.

#1:  ☐ Fill in oval if enrolled in Medicare Part B.  ☐ Easy open caps.  ☐ Print mail service materials in Spanish.

Last Name  

First Name  

MI  

Suffix (JR, SR)  

Alternate Name (Nickname)  

Gender:  ☐ M  ☐ F  

Date of Birth:  MM - DD - YYYY

E-mail address:  

Doctor / Prescriber’s Last Name  

Doctor / Prescriber’s First Name  

Doctor / Prescriber’s Telephone #  

COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

Allergies:  ☐ Aspirin  ☐ Cephalosporin  ☐ Codeine  ☐ Erythromycin  ☐ Peanuts  ☐ Penicillin  ☐ Sulfonamides/Sulfa

Other:  

Health Conditions:  ☐ Arthritis  ☐ Asthma  ☐ Diabetes  ☐ GERD (Acid Reflux)  ☐ Glaucoma  ☐ Heart Condition  

Other:  

Comments/Special Instructions:  

Method of Payment/Shipping Information

Please make check or money order payable to Caremark. Include ID# on check/money order.

☐ Check  ☐ Money Order/Cashier’s Check  ☐ Voucher/Coupon  

(Checks returned for insufficient funds will be subject to a processing fee of up to $40, depending on state law.)

OR pay by credit or debit card (preferred). We accept VISA®, MasterCard®, Discover® and American Express®.

☐ Fill in oval to charge most recently used credit card for this order and future orders for all individuals included in the family.

☐ Fill in oval to charge most recently used credit card for this order only.

To add, change, or update your credit card information, write in below:

Credit/Debit Card Number  MM - YY  Expiration Date

Credit Card Holder Signature  

Date  

Your order will be shipped standard delivery at no charge. Allow 10 to 14 days for standard delivery. If you require faster delivery, mark the appropriate oval below. Expedited delivery only affects shipping time, not processing time of your order. Expedited shipments can only be sent to a street address, not a P.O. Box.

☐ 2nd Business Day = $13 (per order)  ☐ Next Business Day = $18 (per order)  

(Charges subject to change.)

By submitting this form you acknowledge that eligibility under the prescription benefit is subject to Plan verification and that you and your dependents do not have primary prescription coverage under any other plan.