FROM: _____

☐ Please Check Here if New Address

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 802 AVON LAKE OH

POSTAGE WILL BE PAID BY ADDRESSEE

IMMEDIATE PHARMACEUTICAL SERVICES INC
PO BOX 166
AVON LAKE OH 44012-9927

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

HELPFUL HINTS

- Check your prescriptions before you leave your physician's office to make sure that:
  - *the patient's name is legible*
  - *the physician's name is legible*
  - *the exact daily dosage is indicated*
  - *the exact strength is indicated*
  - *the exact quantity is indicated*

  OR have your physician call or fax IPS your new prescription(s). This will ensure prompt delivery.
- In most cases, your prescriptions will be processed and mailed within 48 hours after they are received. There are times when a delay may occur (i.e., clarification is needed from your physician), so please anticipate your needs and allow enough lead time for delivery.
- Please be sure to enclose your payment with your order.
- Please ask your physician for a sufficient supply of your prescription that can be filled at a local pharmacy to cover immediate needs.
- IPS maintains a toll-free customer service line for questions or information regarding the mail service program.

National...Toll-Free: 1-800-233-3872
Fax: 1-800-893-2299

MISSION STATEMENT

- Our mission statement is to provide the highest quality of pharmaceutical care available in the most courteous, convenient, efficient, and cost effective manner available. Our standard of performance is 100 percent quality and 100 percent satisfaction, 100 percent of the time.
- In this manner, we at IPS will work together with our customers to help improve their health and manage their health care costs.

...The Solution

Our Fully Integrated Comprehensive Prescription Drug Program

IPS

Immediate Pharmaceutical Services, Inc.

www.ipsrx.com

Your Mail Service Prescription Drug Program

WHAT IS THE MAIL SERVICE PRESCRIPTION DRUG PROGRAM?

The Mail Service Prescription Drug Program is an extension of your current prescription drug benefit. It is designed to service maintenance medications that are taken on an ongoing basis. Some advantages to this program are as follows:

- ***Convenience of Home Delivery*** – *The medication will be shipped to your home at NO COST to you. Orders will be shipped promptly in protective bubble-wrap envelopes.*
- ***Larger Quantities*** – *In the mail service program, maintenance medication will be shipped up to a 90-day supply at once...a savings of your time and money.*
- ***Toll-Free Customer Service – a national toll-free number*** *is available for order information and pharmacy assistance* ***(1-800-233-3872)****.*
- ***Quality Assurance*** – *Your prescriptions will be dispensed by registered pharmacists and checked before shipment. A comprehensive health profile is maintained on site to monitor potential drug allergies and interactions.*
- ***Tax Receipts Provided*** – *Tax and insurance receipts are included with every order.*
- *In cases where generic substitution is permissible, only generic drugs with the highest FDA-government rating will be used to fill your order.*

HOW DO I USE THE MAIL SERVICE PRESCRIPTION DRUG PROGRAM?

- Ask your physician to prescribe needed medications up to a 90-day supply, plus refills. Please ask your physician to prescribe GENERIC DRUGS whenever possible. (This helps save both you and your employer money!). If you are presently taking medication, ask your physician to give you or mail to you a new prescription for up to a 90-day supply. If you receive a new prescription, ask your physician to write two prescriptions, one for a sufficient supply of your prescription that can be filled at a local pharmacy to cover immediate needs AND one for a 90-day supply with refills.
- Please complete the Confidential Patient Profile insert and include this with your first order only. This will update our records on allergies and general health conditions for your whole family so that we may better serve you.
- Mail your prescriptions to IPS using the enclosed envelope...be certain to include the patient profile insert with your order. We will process the order within 48 hours after IPS receives your order and return your medications to you via UPS or U.S. Mail along with reorder instructions and return envelopes.
- Include payment for your portion of the prescription depending on your benefit plan. IPS accepts Visa, MasterCard, and Discover for your convenience. Contact an IPS Customer Service Representative at 1-800-233-3872 if you have any questions about your co-payment.

WHAT ABOUT GENERIC DRUGS 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. Under these circumstances, IPS will dispense a generic drug when available. This reduces your co-payment and helps save your plan money without a compromise in quality or benefit level. Please ask your physician to prescribe generic drugs whenever possible.

HOW DO I ORDER MY REFILLS?

- Order your refills on your existing prescriptions on-line at our IPS website:

  www.ipsrx.com
- Order your refills on existing prescription through our Interactive Voice Response system (IVR) 24 hours/7 days. By using a touch-tone phone, you may dial our toll-free number (1-800-233-3872) then select "2" to access the automated refill center. It is easy to follow the prompted directions.
- During business hours, you may call an IPS Customer Service Representative.
- Complete your reorder form and return in the IPS self-addressed envelope that accompanies your original order.

WHEN SHOULD I ORDER MY REFILLS?

- Please reorder your refills when you have completed taking 60% of the medication or within 14 days of being out. Check your invoice for the suggested reorder date. When mailing in your refills, please be sure to allow additional time to receive your order.

IPS

DETACH HERE, MOISTEN AND SEAL ENVELOPE

CONFIDENTIAL PATIENT PROFILE

1

Please complete the section below for ***all family members***. This information will be used to check potential drug interactions when you have prescriptions filled through Immediate Pharmaceutical Services, Inc.

FIRST NAME ONLY	ALLERGIES: None	Penicillin	Sulfa	Aspirin	Other	HEALTH CONDITION(S): Thyroid	Diabetes	Glaucoma	Heart Conditions	High Blood Pressure	Other
Member Name											
Spouse											
Child											
Child											

If additional space is needed, please list other allergies or health conditions: _____

PLEASE READ AND SIGN: I certify that the information provided on this form is correct and authorize the release of all information to the plan sponsor, and I AUTHORIZE IMMEDIATE PHARMACEUTICAL SERVICES TO SUBSTITUTE FDA APPROVED GENERIC DRUGS IN ALL CASES WHEN LEGALLY PERMISSIBLE AND CONSISTENT WITH MY PHYSICIAN'S ORDERS AND MY BENEFIT PLAN.

Signature: _____ Date: _____

ENROLLMENT/ORDER FORM FOR NEW PARTICIPANTS

2

Please complete this form, detach and return in enclosed envelope to: **Immediate Pharmaceutical Service, Inc., P.O. Box 166, Avon Lake, Ohio 44012-9927**. Be sure to sign the form and enclose your original prescription(s).

Employer Name _____ Daytime Phone _____ Evening Phone _____

MEMBER I.D. NUMBER _____ Group or Plan Number as on Rx ID Card (if any) _____

Employee Name _____ Date of Birth _____ Sex _____
First MI Last

Address _____
Street City State Zip

Phone _____

Number of prescriptions enclosed _____

Co-payment $ _____ **TOTAL ENCLOSED $** _____

Payment is being made by: **Check** ❑ **Money Order** ❑

or Credit Card ❑. If this option is chosen, you authorize IPS to process amount of order on your credit card. **MasterCard** ❑ **VISA** ❑ **Discover** ❑

Credit Card Number _____

Expiration Date _____

Unless box below is checked, your credit card will be kept on file and you are authorizing its use for future orders

❑ *I do not want my credit card used for future orders.*

Signature _____

OTHER FAMILY MEMBERS ELIGIBLE FOR PRESCRIPTION DRUG PROGRAM

Please Print

3

Spouse _____ **Date of Birth** _____ **Sex** _____
First MI Last

Child _____ **Date of Birth** _____ **Sex** _____
First MI Last

Child _____ **Date of Birth** _____ **Sex** _____
First MI Last

Child _____ **Date of Birth** _____ **Sex** _____
First MI Last

Did You Remember To...

- *Detach and complete your patient profile questionnaire?*
- *Enclose your written prescriptions from your physician?*
- *Detach, complete and enclose your order form?*
- *Enclose your co-payment or credit card information?*
- *Enclose all 3 shaded sections in the attached envelope?*

Thank You!