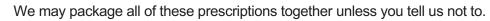


|  |   | Mail this form to:                                |                                  |
|--|---|---|----------------------------------|
| Enter ID # below if not s  | hown or if different from abc   | CVS CAREMARK<br>PO BOX 94467<br>PALATINE, IL 60   |                                  |
| Prescription Plan Spon   |   |   |                                  |
| New Prescriptions - N<br>Refills - Order by Web,<br>FOR FASTEST SERVE<br>prescription benefit ID | <i>l</i> ail your new prescriptions<br>phone, or write in Rx numb<br><b>CE</b> , order refills at www.ca<br>Card. | ber(s) below. Numb<br>aremark.com or call the num | per of <b>New</b> prescriptions: |
| Last Name Street Name  |   | First Name<br>Apt./Suite #                        | MI Suffix (JR, SR)               |
| City Daytime Phone #:  |   | State   |                                  |
| B Refills. To order ma   | il service refills, enter your  | prescription number(s) here                       |                                  |
|  |   | 3)  | _ 4)                             |
| 1)   | 2)  |   |                                  |





**C** Tell us about the people getting prescriptions. If there are more than two people, please complete another form.

|   | I NAME M Suffix  |
|---|--|
| NICKNAME Gender: () M () F Date of Birl   |  |
|   | te new prescription written:   |
|   |  |
| Doctor's Last Name Doctor's First Name  | Doctor's Phone #   |
| Tell us about new allergies or health information for this person         Allergies:       None       Aspirin       Cephalosporin       Codeine         Sulfa       Other:  | on. Only tell us about <b>new</b> information.<br>() Erythromycin () Peanuts () Penicillin   |
| Health Information:       Arthritis       Asthma       Diabetes       Acid         High Blood Pressure       High Cholesterol       Migraine       O         Other:   |  |
| 2nd person with a refill or new prescription. This person needs:(   | Easy open caps Ospanish forms and labels   |
|   | NAME  Suffix    (JR,SR)  |
| NICKNAME Gender: OM OF Date of Birl   | $th: \mathbb{M}[\mathbb{M}] - \mathbb{D}[\mathbb{D}] - \mathbb{Y}[\mathbb{Y}] \mathbb{Y}[\mathbb{Y}]$  |
| Your E-Mail: Da   | te new prescription written:   |
| Doctor's Last Name Doctor's First Name  | Doctor's Phone #   |
| Tell us about <b>new</b> allergies or health information for this perso   |  |
| Health Information: () Arthritia () Acthma () Diabataa () Acid  |  |
| Health Information:       Arthritis       Asthma       Diabetes       Acid         High Blood Pressure       High Cholesterol       Migraine       O         Other:   | Osteoporosis () Prostate Issues () Thyroid   |
|   | Osteoporosis O Prostate Issues O Thyroid   |
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