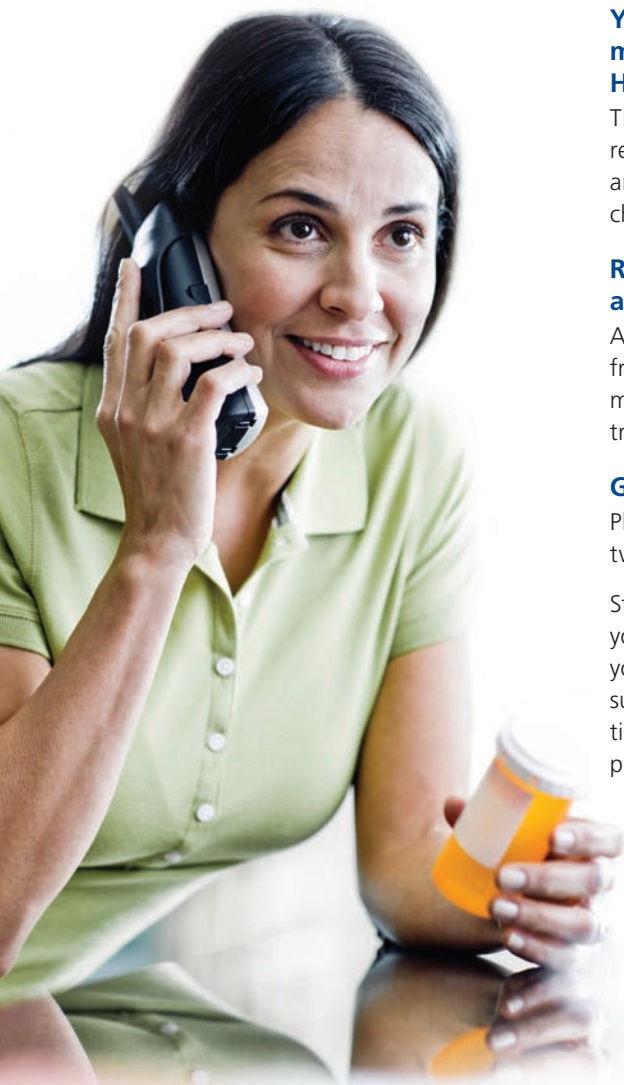


# How to use Aetna Rx Home Delivery®



## You can order your maintenance medications through Aetna Rx Home Delivery

These are medications that you take regularly to treat chronic conditions like arthritis, asthma, diabetes, high cholesterol, heart conditions and others.

## Receive up to a 90-day supply, if approved by your doctor

A 90-day supply lets you get the most from your plan. A longer supply of medication can also help you to stay on track with your therapy.

## Get started now

Placing your first order is a quick, two-step process:

Start by getting two prescriptions for your maintenance medications from your doctor. Use one to get a short-term supply at your local pharmacy. Then, save time and money by sending your other prescription to Aetna Rx Home Delivery:

- **Step 1:** Get a prescription from your doctor for each maintenance medication (typically a 90-day supply).
- **Step 2:** Complete and mail an order form along with your new prescription(s) and payment to Aetna Rx Home Delivery. Please write your date of birth and Aetna Member ID on all documents, including prescriptions.
- **Or:** Have your doctor fax your prescription(s) with completed order form.

## Track and refill your order online

You can go online to order refills, track your order and more, without ever leaving home. Just go to **Aetna.com**, then log on to our secure member website, Aetna Navigator®.

You can also order your refills by mail using the convenient reorder form included with your first shipment. Or call our toll-free number to order by phone.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits coverage include: Aetna Health Inc., Aetna Health of California Inc., Aetna Health of the Carolinas Inc., Aetna Health of Illinois Inc., Aetna Health Insurance Company of New York, Corporate Health Insurance Company and/or Aetna Life Insurance Company (Aetna).

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., that is a licensed pharmacy providing mail-order prescription services.

This material is for educational purposes only and does not constitute a contract. Information is believed to be accurate as of the production date; however, it is subject to change.

We want you to know®







**WE WILL DISPENSE FDA-APPROVED GENERIC-EQUIVALENT MEDICATION WHEN AVAILABLE AND APPROPRIATE AS INDICATED ON YOUR PRESCRIPTION.**

**SECTION 5 New Prescription Order**

Fill out the information below and enclose new prescription(s) and payment with this form

<input type="text"/>	<input type="radio"/> Self	<input type="radio"/> Spouse	<input type="radio"/> Dependent	<input type="checkbox"/> Sex M / F	<input type="text"/>	<input type="text"/>
Patient First Name					Date of Birth	Doctor Phone Number
<input type="text"/>					<input type="text"/>	<input type="text"/>
Doctor Last Name					Drug Name	

<input type="text"/>	<input type="radio"/> Self	<input type="radio"/> Spouse	<input type="radio"/> Dependent	<input type="checkbox"/> Sex M / F	<input type="text"/>	<input type="text"/>
Patient First Name					Date of Birth	Doctor Phone Number
<input type="text"/>					<input type="text"/>	<input type="text"/>
Doctor Last Name					Drug Name	

<input type="text"/>	<input type="radio"/> Self	<input type="radio"/> Spouse	<input type="radio"/> Dependent	<input type="checkbox"/> Sex M / F	<input type="text"/>	<input type="text"/>
Patient First Name					Date of Birth	Doctor Phone Number
<input type="text"/>					<input type="text"/>	<input type="text"/>
Doctor Last Name					Drug Name	

**SECTION 6 Refills - Please send in refill slips for medications you would like to order. If you do not have your refill slip please complete the section below.**

**Print Prescription Number Here**  
-  
**Drug Name:** \_\_\_\_\_

**Print Prescription Number Here**  
-  
**Drug Name:** \_\_\_\_\_

**Print Prescription Number Here**  
-  
**Drug Name:** \_\_\_\_\_

**Print Prescription Number Here**  
-  
**Drug Name:** \_\_\_\_\_

**SECTION 7 Allergies & Health Conditions**

Complete this section only if adding a new customer or there are changes to existing customer Allergies or Health Conditions.

If no allergies are selected, for new customers, this indicates no known allergies. For existing customers, this indicates no change from information provided to Aetna Rx Home Delivery previously.

<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cardholder's First Name	Date of Birth	None	Penicillin	Sulfa	Codeine	Aspirin	Erythromycin	NSAIDS	Other (write in below)	Diabetes	High Blood Pressure	Asthma	GI/GERD	High Cholesterol	Other (write in below)
<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dependent's First Name	Date of Birth														
<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other Dependent's First Name	Date of Birth														
<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other Dependent's First Name	Date of Birth														

Please write the person's name and list their Other Allergies and/or Health Conditions referenced above: \_\_\_\_\_

**Please Note:** By submitting this form you verify that the information is correct, that the prescriptions enclosed are for use by eligible participants and authorize the release of all information to the Plan Sponsor, administrator, or underwriter. All communications regarding this account will be directed to the member (employee/retired). If a spouse or other eligible dependent wishes to direct their communications to an alternate address or telephone number, they may make this request by completing the Confidential Communications Request form provided in the Privacy Notice, or as available on our website.