

Monday-Friday – 7:00 am to 9:00 pm CST • Saturday – 8:00 am to 6:00 pm CST • Sunday – 9:00 am to 5:00 pm CST

1 PATIENT INFORMATION

Name: _____ E-mail Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Cardholder ID: _____

Group ID: _____

Phone: - -

D.O.B.: - -

Maxor will keep this address on file for all orders filled on this account until another address is provided.

Sex: Male Female

**For address changes, please call
Maxor Mail Order at (800) 687-8629.**

Relationship to Cardholder:

Self Spouse Child

2 DRUG ALLERGIES & CHRONIC ILLNESSES

Drug Allergies: None Codeine Sulfa Aspirin Penicillin Other _____

Severity of Drug Allergies: Mild Moderate Severe Intolerance Anaphylaxis

Chronic Illnesses: Thyroid High Blood Pressure Diabetes Glaucoma
(Disease States) Heart Condition Intestinal Disorders Lung Condition Other _____

3 GENERIC MEDICATION INFORMATION

In accordance with Texas Pharmacy Law and availability Maxor Pharmacy will always dispense a generic medication with a lower co-payment unless you specify otherwise. Please contact a customer care associate at (800) 687-8629 to advise us of medications that you want dispensed brand-name only or use the space provided on the reverse side of this form to notify us of brand-name only medication exceptions.

¹Please refer to the reverse side of this form for further details.

4 PAYMENT METHOD

In order to process your prescriptions quickly, please enclose the correct co-payment amount(s). If assistance is needed with calculating co-payment amount(s), please call MaxorPlus at (800) 687-0707.

Payment Options: Check/Money Order Credit Card

Paying By Credit Card?

Visa MasterCard Discover American Express

Credit Card Number:

Expiration Date:

MM/YYYY

Check here to decline keeping credit card information on file at the pharmacy.

Credit card already on file.

X

Signature of Cardholder

Expedited Shipping via UPS or FedEx: \$25.00 for overnight shipping \$15.00 for 2-day shipping

Note: Expedited shipping will **not** rush prescription processing. Prices subject to change.

Use reverse side for prescription refills.

5 ORDER REFILLS

Brand-Name Only Medication Exceptions:

Rx Number	Name of Medication	Strength	Doctor's Name	Co-payment

Order Refill Prescriptions Here:

Rx Number	Name of Medication	Strength	Doctor's Name	Co-payment

Questions? Call Maxor Pharmacy toll-free at (800) 687-8629,
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6 HOW TO ORDER

HOW TO ORDER REFILLS

BY MAIL: Complete the payment and refill sections, and mail to Maxor Mail Order.

BY PHONE: Call toll free (800) 687-8629 or (806) 324-5500 and use our automated system to enter the Rx number printed on your prescription label, or speak to a customer service representative during normal business hours.

BY INTERNET: You may refill your prescriptions on our website at www.maxor.com. Please choose the REFILL PRESCRIPTIONS section under FILLING YOUR PRESCRIPTIONS. You will need your prescription numbers and credit card information available.

HOW TO ORDER NEW PRESCRIPTIONS

BY MAIL: Complete the payment and patient information sections, enclose your new prescriptions, and mail to Maxor Mail Order.

BY PHONE: Have your doctor call in new prescriptions to (800) 687-8629 or (806) 324-5500.

BY FAX: Your doctor can fax new prescriptions to (866) 589-7656. In accordance with Texas law, only your doctor can fax new prescriptions.

7 IMPORTANT INFORMATION

¹ The submission of this form, for you or any of your dependents, authorizes the release of all information to the Plan Sponsor, Administrator, or Underwriter, and authorizes the prescription to be filled with the generic equivalent when available and permissible by law, in accordance with your benefit plan requirements. If you request a brand name drug when your doctor permits substitution, you may be responsible for paying the difference in cost between the brand name drug and the generic equivalent plus a co-payment. Refer to your plan benefit information for more details or contact a customer care associate at (800) 687-8629.

Reminder: You will always be charged the mail order co-pay when you send or transfer a prescription to Maxor Mail Order. To maximize your savings, ask your doctor for a 90 day supply with refills up to one year.

Written information about this prescription has been provided for you. Please read this information before you take this medication. If you have questions concerning this prescription, a pharmacist is available during normal business hours to answer your questions. Please call your pharmacy.

Complaints against the practice of pharmacy may be filed with the:

Texas State Board of Pharmacy
William P. Hobby Building, Suite 3-600
333 Guadalupe, Box 21
Austin, Texas 78701-3942 • (512) 305-8000
To receive a complaint form call
(800) 821-3205 or (512) 305-8080 if in Austin.
(recorded information only)
www.tsbp.state.tx.us

Se la presentado a usted la informacion por escrito sobre esta receta. Favor de leer esta informacion antes de tomar el medicamento. Si usted tiene preguntas tocante a esta receta, estara un farmaceutico disponible durante las horas de negocio para contestar sus preguntas. Por favor llame a su farmacia.

Quejas contra la practica de la farmacia pueden ser reportadas al:

Concilio de Farmacia Del Estado De Tejas
William P. Hobby Building, Suite 3-600
333 Guadalupe, Box 21
Austin, Texas 78701-3942 • (512) 305-8000
Para recibir una forma de queja llame:
(800) 821-3205 or (512) 305-8080 if in Austin.
(informacion grabada solamente)
www.tsbp.state.tx.us

This form is used to order refills or new prescriptions. Please mail this form 14 days in advance before your medication runs out and enclose the appropriate co-payment amount.