



PRESCRIPTION DRUG MAIL ORDER ENROLLMENT

Orchard Pharmaceutical Services is a mail order pharmacy for its members. Orchard offers **home delivery** of monthly medications with **NO shipping or handling fees** for standard delivery. You may receive up to a 90 day supply of most medications delivered right to your door before you are out of medication.

To obtain your mail order prescriptions from Orchard you will need to create an account. You can create an account before you are ready to order. To create an account and enroll in Orchard you must do one of the following:

- ▶ Complete the Enrollment Form
- ▶ Mail to Orchard Pharmaceutical Services, Inc., at: **P.O. Box 3094, North Canton, OH 44720**; or
- ▶ Enroll on-line at **www.orchardrx.com**; or
- ▶ Enroll via telephone at **1-866-909-5170** or TTY 711 (M-F 8am-10pm Saturday 8am-4:30pm)

M E M B E R I N F O R M A T I O N

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt #: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Group Number: \_\_\_\_\_ Member Identification Number : \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex:  M  F E-Mail: \_\_\_\_\_  
**Drug Allergies:**  No Known Allergies  Erythromycin  Penicillin  Codeine  Aspirin  
 Sulfa  Other: \_\_\_\_\_

P A Y M E N T I N F O R M A T I O N

**CREDIT CARD:**  Visa  Mastercard  Discover  AMEX  
 Print name as it appears on card: \_\_\_\_\_  
 Card Number: \_\_\_\_\_ Exp. Date MM/YYYY: \_\_\_\_\_ CVV: \_\_\_\_\_

\_\_\_\_\_ Please initial this line to authorize Orchard to charge your credit card to pay for each pharmacy order. Charge dates and amounts will vary with each order.

**SIGNATURE:** \_\_\_\_\_

**If paying by check or money order, mail payment to Orchard Pharmaceutical Services.**

Mail your original prescriptions with this Enrollment Form or have your doctor fax them directly to 1-866-909-5171.

Once we begin to fill your prescriptions you may order refills 24 hours/7 days a week by calling 1-866-909-5170 or TTY 711 (M-F 8am-10pm Saturday 8am-4:30pm) to speak with a representative or our automated system. You may also order refills on-line at our website at [www.orchardrx.com](http://www.orchardrx.com)

### SPECIAL HANDLING

\_\_\_\_\_ Please initials on this line if you do NOT want child-proof caps mailed to your household. Snap caps or easy off lids will be sent with your medications if this line is initialed.

**GENERICS:** Orchard Pharmaceuticals will automatically dispense the generic drug unless your prescriber writes "D A W" (dispense as written) on the prescription and the brand name drug is medically necessary. Brand name drugs typically require you to pay a higher co-payment.

### USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 states that you have the right to have one or more persons act as your representative to make decisions about the uses and sharing of your protected health information. You can limit the amount of protected health information that the authorized personal representative(s) can decide about, and you can cancel this at any time.

### DESIGNATION OF PERSONAL REPRESENTATIVE

I, (Name) \_\_\_\_\_ (Date of Birth) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ hereby name the following person to act as my authorized personal representative with respect to decisions involving the use and/or sharing of protected health information that pertains to me.

\_\_\_\_\_  
(Print Name of Personal Representative)

\_\_\_\_\_  
(Relationship of Personal Rep to Member)

\_\_\_\_\_  
(Phone Number of Personal Representative)

**PLEASE CHECK ONLY ONE BELOW:**

The person named above is to be given all of the privileges that would be given to me with respect to my protected health information;

**OR**

The person named above is acting as my designated personal representative ONLY for the following function(s): \_\_\_\_\_

I understand that I may cancel this designation at any time by contacting Orchard at **1-866-909-5170** or TTY 711 (M-F 8am-10pm Saturday 8am-4:30pm). I understand any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

**SIGNATURE:**

**DATE:**