BlueCross BlueShield Federal Employee Program®

allianceRx Walgreens + PRIME

Specialty Medicine Order Form

For Service Benefit Plan Members

Enter ID # below if not shown or if different from above

Blue Cross and Blue Shield Federal Employee Program
Plan Sponsor or Company Name Prescription

Mail this form to:

AllianceRx Walgreens Prime
P.O. Box 692169
Orlando, FL 32869

Please use **blue** or **black ink**, CAPITAL LETTERS and fill in **both sides** of this form.

New prescriptions – Mail your new prescriptions with this form. Number of **New** prescriptions:

Refills – Order online, by phone or write in Rx number(s) below. Number of **Refill** prescriptions:

For ***fastest service,*** order refills toll-free at 1-888-346-3731.

A Shipping Address. To ship to an address different from the one printed above, please make changes here.

Last name First name MI Suffix (Jr, Sr)

Street address Apt/Suite #

○ Use this address for this order only.

City State ZIP Code

Daytime phone # Evening phone #

B Refills. To order refills by mail, enter your prescription number(s) here.

1)_____ 2)_____ 3)_____ 4)_____

5)_____ 6)_____ 7)_____ 8)_____

On behalf of the Blue Cross and Blue Shield Service Benefit Plan, AllianceRx Walgreens Prime administers the Specialty Pharmacy Program. AllianceRx Walgreens Prime is an independent company that provides specialty drugs to Service Benefit Plan members.

We may package all of these prescriptions together unless you tell us not to.

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

1st person with a refill or new prescription. This person needs: ◯ Spanish forms and labels

Last name | First name | MI | Suffix (Jr, Sr)

Nickname | Gender: ◯ M ◯ F | Date of birth (MM-DD-YYYY)

Email | Date new prescription was written

Doctor's last name | Doctor's first name | Doctor's phone #

Tell us about new allergies or health information for this person. Only tell us new information.

Allergies: ◯ None ◯ Aspirin ◯ Cephalosporin ◯ Codeine ◯ Erythromycin ◯ Peanuts ◯ Penicillin ◯ Sulfa ◯ Other: _____

Health information: ◯ Arthritis ◯ Asthma ◯ Diabetes ◯ Acid reflux ◯ Glaucoma ◯ Heart problems ◯ High blood pressure ◯ High cholesterol ◯ Migraine ◯ Osteoporosis ◯ Prostate issues ◯ Thyroid ◯ Other: _____

2nd person with a refill or new prescription. This person needs: ◯ Spanish forms and labels

Last name | First name | MI | Suffix (Jr, Sr)

Nickname | Gender: ◯ M ◯ F | Date of birth (MM-DD-YYYY)

Email | Date new prescription was written

Doctor's last name | Doctor's first name | Doctor's phone #

Tell us about new allergies or health information for this person. Only tell us new information.

Allergies: ◯ None ◯ Aspirin ◯ Cephalosporin ◯ Codeine ◯ Erythromycin ◯ Peanuts ◯ Penicillin ◯ Sulfa ◯ Other: _____

Health information: ◯ Arthritis ◯ Asthma ◯ Diabetes ◯ Acid reflux ◯ Glaucoma ◯ Heart problems ◯ High blood pressure ◯ High cholesterol ◯ Migraine ◯ Osteoporosis ◯ Prostate issues ◯ Thyroid ◯ Other: _____

D **Special instructions:** _____

E **How would you like to pay for this order?** Fill in the oval to choose a payment method.

◯ **Electronic check.** Pay from your bank account. Call Customer Care at 1-888-346-3731.

◯ **Credit or debit card.** (Visa®, MasterCard®, Discover®, or American Express®)

◯ Fill in this oval to use your card on file.

◯ Fill in this oval to use a new card or to update your card expiration date.

Account # | Exp. Date (MMYY) | Cardholder signature/date

◯ Fill in this oval if you **DO NOT** want to use this payment method for future orders.