

Home Delivery Registration Form

CastiaRx Medicare Part D Members

Welcome to CastiaRx Home Delivery! Follow the four steps on this form and you'll be registered for home delivery of your maintenance medications, which can save you time and money.

1. Provide your background information



Patient Information

_____ FIRST NAME		_____ LAST NAME	
_____ GROUP NUMBER		_____ MEMBER ID	
_____ DATE OF BIRTH		_____ PHONE NUMBER	
_____ SHIPPING ADDRESS		_____ CITY	
_____ STATE	_____ ZIP	_____ EMAIL	_____ ALTERNATE PHONE NUMBER

Male
 Female

Prescription and Prescriber Information

CastiaRx will contact your prescriber for a new 90-day prescription

Medication Name & Strength	Prescriber Name	Prescriber Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have questions regarding my medication(s) and would like a pharmacist to call me

Questions?

Call **866-516-1121** // TTY **866-706-4757** H2773_QHPNY1170_C
Visit **CastiaRx.com**

Form continues >

1. Background information (continued)



Allergies

- Aspirin Sulfonamide
 Penicillin None
 Codeine Other: _____

Health Conditions

- Arthritis High Blood Pressure
 Diabetes High Cholesterol
 Glaucoma Intestinal Disorder(s)
 Heart Condition Lung Condition
 Other: _____

2. Provide your payment information

You may pay with a major credit/debit card, electronic check, check or money order. Payment must be received before an order is shipped. To simplify the refill process, authorize CastiaRx Pharmacy to keep your credit/debit card on file.

- Credit/Debit Card Authorize this card to remain on file for all future payments
 FSA/HSA Card Call me to authorize this card before filling each order
 Electronic Check* *A representative will contact you with your total, please don't
 Check/Money Order* send any payment with this form

I understand that applicable prescription costs will be charged by CastiaRx Pharmacy to the credit card provided. I also understand by signing this form that prescription medications cannot be returned to the pharmacy for credit unless in response to a recall, defect in a medical device, or otherwise pre-approved by the pharmacy. A medication return for any reason will result in its immediate destruction and shall not be available for credit.

_____	CARD NUMBER	_____	CVV CODE
_____	NAME (as it appears on card)	_____	EXPIRATION DATE

BILLING ADDRESS (if different from shipping)			
_____	CARDHOLDER SIGNATURE	_____	DATE

3. Check your work and authorize

I certify that the patient information entered on this form is correct and that the patient named is eligible for benefits under the prescription drug program and authorize the release of all information to the plan administrator. The information on this form will remain private, and will be used to fill your prescriptions and monitor for any harmful drug/disease interactions. I authorize the release of any medical information required to process this claim.

SIGNATURE (required to process order)

DATE OF SIGNATURE

Questions?

Call **866-516-1121** // TTY **866-706-4757**
Visit **CastiaRx.com**

Form continues >

4. Submit this form



Registration forms may be submitted by:

Mail: CastiaRx Pharmacy
701 Emerson Road, Suite 301
Creve Coeur, MO 63141

Fax: 877-649-1910
Email: HomeDelivery@CastiaRx.com

CastiaRx will contact your prescriber for a 90-day prescription, or you can have your prescriber send a 90-day prescription via **ePrescribe** (NABP# 2611590, NPI# 1285737411), **fax** or **mail**. We are unable to accept prescriptions via email.

Have a new prescription that you need filled?

If it's your first time using CastiaRx Home Delivery, complete and submit this registration form. If you're already enrolled, have your prescriber submit your prescription by:

ePrescribe to CastiaRx, NABP#: 2611590, NPI#: 1285737411.

Fax to CastiaRx at 877-649-1910. It must include a fax cover sheet from the prescriber's office.

Mailing the original prescription to CastiaRx Pharmacy, 701 Emerson Road, Suite 301, Creve Coeur, MO 63141.

Your prescriber must write the prescription for a 90-day supply and show the exact quantity to be dispensed.



If you ever have a question about your medications, shipments or billing, our support specialists are available by phone.

Call **866-516-1121** // TTY **866-706-4757**

ATTENTION: CastiaRx complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. If you speak another language, language assistance services, free of charge, are available to you. Call 1-866-516-1121 (TTY: 1-866-706-4757).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-516-1121 (TTY: 1-866-706-4757). // CastiaRx cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-516-1121（TTY：1-866-706-4757）。 // CastiaRx 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。