Innoviant®
Pharmacy Inc.

Mail Service Pharmacy

Getting Started

If this is the first time you have used Innoviant Pharmacy, Inc. to fill your prescriptions, you must complete ***BOTH*** the enrollment and order forms.

If you have already used Innoviant Pharmacy, Inc. and are simply sending in a new prescription, you ***ONLY*** need to complete information on the order form.

Instructions

- Fill out the form(s) with black ink and print clearly in UPPERCASE letters.
- Refer to your prescription ID card for PCN, group and member ID numbers.
- Place the form with your original written prescription(s) and applicaple copayment in an envelope and mail to: **Innoviant Pharmacy, Inc., P.O. Box 400, Hatboro PA, 19040-0400.** Failure to provide the appropriate copayment may delay the processing of your order.

Refills

You can order refills by phone at 1.888.Rx.REFIL (**1.888.797.3345**) or online at www.innoviantrx.com. Have your prescription number, ZIP Code, credit card and expiration date ready.

Please note: Most prescriptions expire after one year and cannot be refilled even if the prescription label indicates you have refills remaining.

Customer Service

We are available to assist you 24-hours a day, 7 days a week at **1.877.390.9200**.
Our call volume is high on Mondays and peaks daily between 11 a.m. and 3 p.m., CT.
For faster service, please call at an alternate time. Thank you for helping us serve you better.

Please report any shortage, damage or non-receipt of order within 30 days.

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ENROLLMENT FORM

ID

BIN #: 6 1 0 1 2 7

Rx PCN #: ________ (8 DIGITS) Rx Group #: ________ (8 DIGITS)

Member ID #: ________________ (INCLUDE ZEROS. MAY NOT USE ALL SPACES.)

ENROLLEE #1

Name: ______________________

Address: ______________________

City: ______________________ State: __ ZIP Code: _____

Email Address: ______________________

Date of Birth

MM/DD/YYYY

Gender

○ Male ○ Female

Dependent Code
(if applicable) __

Drug Allergies

○ Codeine ○ Erythromycin ○ Penicillin
○ Sulfa ○ No Known ○ Other: ________

Health Conditions

○ Arthritis ○ Diabetes ○ Glaucoma
○ Hypertension ○ Heart Disease ○ Stomach Disorders
○ Thyroid Disease ○ No Known ○ Other: ________

ENROLLEE #2

Name: ______________________

Address: ______________________

City: ______________________ State: __ ZIP Code: _____

Email Address: ______________________

Date of Birth

MM/DD/YYYY

Gender

○ Male ○ Female

Dependent Code
(if applicable) __

Drug Allergies

○ Codeine ○ Erythromycin ○ Penicillin
○ Sulfa ○ No Known ○ Other: ________

Health Conditions

○ Arthritis ○ Diabetes ○ Glaucoma
○ Hypertension ○ Heart Disease ○ Stomach Disorders
○ Thyroid Disease ○ No Known ○ Other: ________

ENROLLEE #3

Name: ______________________

Address: ______________________

City: ______________________ State: __ ZIP Code: _____

Email Address: ______________________

Date of Birth

MM/DD/YYYY

Gender

○ Male ○ Female

Dependent Code
(if applicable) __

Drug Allergies

○ Codeine ○ Erythromycin ○ Penicillin
○ Sulfa ○ No Known ○ Other: ________

Health Conditions

○ Arthritis ○ Diabetes ○ Glaucoma
○ Hypertension ○ Heart Disease ○ Stomach Disorders
○ Thyroid Disease ○ No Known ○ Other: ________

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ID

Member ID #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(INCLUDE ALL ZEROS. MAY NOT USE ALL SPACES.)

ORDER FORM

BRAND*

IT IS STANDARD PHARMACY PRACTICE TO DISPENSE A GENERIC EQUIVALENT WHEN AVAILABLE. BY CHECKING "**DISPENSE BRAND (NO GENERICS)**" YOU ARE REQUESTING THE BRAND NAME PRODUCT EVEN IF A GENERIC IS AVAILABLE, MEANING YOU MAY BE RESPONSIBLE FOR A HIGHER COPAYMENT OR THE ENTIRE COST OF THE BRAND NAME MEDICATION. REFER TO YOUR PLAN DOCUMENTS FOR INFORMATION OR CALL **1.877.390.9200.**

PATIENT AND PRESCRIPTION INFO

Patient Information

Name: ____________________

Phone: ☐☐☐-☐☐☐-☐☐☐☐

Date of Birth: MM/DD/YYYY

Doctor Information

Name: ____________________

Phone: ☐☐☐-☐☐☐-☐☐☐☐

Rx Information

Rx Name: ____________________ COPAY $☐☐☐

◯ DISPENSE BRAND (NO GENERICS)*

Rx Name: ____________________ COPAY $☐☐☐

◯ DISPENSE BRAND (NO GENERICS)*

Rx Name: ____________________ COPAY $☐☐☐

◯ DISPENSE BRAND (NO GENERICS)*

Patient Information

Name: ____________________

Phone: ☐☐☐-☐☐☐-☐☐☐☐

Date of Birth: MM/DD/YYYY

Doctor Information

Name: ____________________

Phone: ☐☐☐-☐☐☐-☐☐☐☐

Rx Information

Rx Name: ____________________ COPAY $☐☐☐

◯ DISPENSE BRAND (NO GENERICS)*

Rx Name: ____________________ COPAY $☐☐☐

◯ DISPENSE BRAND (NO GENERICS)*

Rx Name: ____________________ COPAY $☐☐☐

◯ DISPENSE BRAND (NO GENERICS)*

SHIPPING

Shipping Address

Address: ____________________

City: ____________________ State: ☐☐ ZIP Code: ☐☐☐☐☐

SOME MEDICATIONS REQUIRE SPECIAL HANDLING AND CANNOT BE SHIPPED TO A POST OFFICE BOX.

SHIPPING $☐☐

Shipping Method

◯ Standard	(USPS First Class)	$0
◯ Priority	(2-3 days)	$15
◯ Overnight	(1 day)	$30

PLEASE ALLOW ABOUT TWO WEEKS FOR STANDARD DELIVERY. ALL ORDERS ARE SENT BY STANDARD DELIVERY UNLESS YOU SELECT A DIFFERENT SHIPPING METHOD. POST OFFICE BOXES CANNOT ACCEPT EXPEDITED DELIVERY SERVICES.

PAYMENT

Method of Payment

FAILURE TO INCLUDE APPROPRIATE COPAYMENT MAY DELAY THE PROCESSING OF YOUR ORDER.
MAKE PAYMENTS TO INNOVIANT PHARMACY, INC. PLEASE DO NOT SEND CASH.

◯ Check

◯ Money Order

◯ Credit Card ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

____________________ NAME ON CARD ☐☐/☐☐ EXPIRATION

◯ MasterCard ◯ Visa ◯ Discover ◯ American Express

◯ I authorize charges for future orders to be billed to this card (call to remove or update)

◯ I authorize charges for all dependents to be billed to this card

Total $☐☐☐

SIGN

I certify that I have read and understand Innoviant Pharmacy, Inc.'s Notice of Privacy (available at www.innoviantrx.com). I further authorize the release of all information to Innoviant Pharmacy, Inc. and other necessary parties as required to process any prescription(s) and refills under my benefit plan.

SIGNATURE REQUIRED ____________________

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