Duke University
HUMAN RESOURCES
BENEFITS ADMINISTRATION

Please follow the directions on the order form and mail your prescription drug order to:

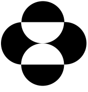
Merck-Medco Rx Services of Texas L.L.C.
PO Box 650322
Dallas, TX 75265-0322

If you have any questions regarding your medications or your prescription drug benefit, please contact Merck-Medco Member Services at:

1-800-717-6575

or visit the Merck-Medco website at:

www.merckmedco.com



Merck-Medco
Managed Care, L.L.C.

How to use your online mail service forms:

1. Print the Order Form for the New Prescriptions AND the Health, Allergy & Medication Questionnaire.

2. Once the forms are printed, be sure to complete all information areas in full. Remember that the profile questionnaire is only needed if this is your first order or if there has been a change you need to let the pharmacist know about.

3. Cut the Order Form for New Prescriptions along the dotted lines where indicated, and place both forms, along with your new or renewal prescription from your doctor into a standard, white, business-size #10 envelope.

4. Write or type the address of your mail service pharmacy on the front of the envelope and mail to Merck-Medco Rx Services.

ORDER FORM FOR NEW PRESCRIPTIONS

MEMBER ID NUMBER

Use Member's ID/Social Security Number

GROUP NUMBER

PAYMENT METHOD
☐ Credit Card ☐ American Express ☐ Discover/Novus ☐ Mastercard
☐ VISA ☐ Diners Club ☐ Check ☐ Money Order

Bill all future orders to this credit card number? ☐ YES ☐ NO

ACCOUNT NUMBER

EXPIRATION DATE

X
CARDHOLDER'S SIGNATURE

You authorize release of all information to the plan administrator, underwriter, sponsor, policyholder, employer, and their agents for use in connection with the benefit plan programs. Information may also be used for other reporting and analysis purposes without identification of you or your family members.

Group Name ______
Member's Name ______
Mailing Address ______ Apt. # ______
City ______ State ______ Zip ______
Telephone # Day ______ Evening ______
☐ Temporary Address

PATIENT INFORMATION

LAST NAME	FIRST NAME	DATE OF BIRTH	SELF	SPOUSE	DEPENDENT	DOCTOR'S NAME	DOCTOR'S PHONE

Total number of prescriptions enclosed: ______ If paying by check, total payment enclosed ______

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Merck-Medco Rx Services: Health, Allergy, & Medication Questionnaire

Your answers to the following questions will help us provide your pharmacy benefit services including, for example, filling prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know if you have any known allergies, conditions or diseases.

- **Please print the questionnaire and provide responses for each person in the household eligible for pharmacy benefits with Merck-Medco Rx Services.**
- **Return the questionnaire with your prescription or refill order form.**

Member Identification and Contact

Group Number ______ Member Number ______ Daytime Telephone Number ______

First Name ______ M.I. ______ Last Name ______

Street Address/ Apt. No. ______ City ______ State ______ Zip ______

Drug Allergy Conditions

For each covered family member, include name, date of birth and gender. For each family member check the box **ONLY** if an allergy or bad reaction happened anytime in the past. If your medication is not listed, please print the name of the medication in the bottom section of this chart.

Correct way to mark circles: ● Please use blue or black ink.

	Member	Spouse	Dependent	Dependent	Dependent
First Name:					
Last Name: (If different from member)					
Date of Birth: (mm/dd/yy)					
Gender:	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F
Penicillins Cephalosporins Antibiotics (e.g. Ampicilin, Keflex)	○	○	○	○	○
Tetracycline Antibiotics	○	○	○	○	○
'Mycin' drugs (e.g. Erythromycin)	○	○	○	○	○
Codeine (e.g. Tylenol # 3)	○	○	○	○	○
Non-steroidal anti-inflammatory (NSAID) drugs (e.g Ibuprofen)	○	○	○	○	○

Aspirin (Salicylates)					
Sulfa drugs					
Iodine					
Print additional allergies as needed -->					

Medical Conditions- Please check the box **ONLY** if a doctor ever said you or a family member have any of the following conditions.

	Member	Spouse	Dependent	Dependent	Dependent
Heart failure (weak heart)					
High blood pressure (hypertension)					
Heart attack or angina					
High Cholesterol (hypercholesterolemia)					
Stroke					
Chronic bronchitis or emphysema (COPD)					
Asthma					
Allergies, runny nose, hay fever (allergic rhinitis)					
High blood sugar (diabetes)					
Thyroid disease					
Peptic, stomach, or duodenal ulcer					
Gastric reflux, heartburn, or esophagitis (GERD)					
Inflammatory bowel disease (colitis, Crohn's disease)					
High pressure in the eyes (glaucoma)					
Seizures					
Poor circulation in the legs (peripheral vascular disease)					
Trouble with blood not clotting properly					
Enlarged prostate (benign prostatic hyperplasia, BPH)					
Arthritis					
Osteoporosis					

Depression	○	○	○	○	○
Migraine headache	○	○	○	○	○
Print additional conditions as needed -->					

Information you provide may be released to and used by the plan administrator, sponsor, employer and/or their agents in connection with the benefit plan program. Information may be used for other reporting and analysis purposes without identifying you or your family members.

Did you complete **all** pages? **Please return the questionnaire with your prescription order form.**

Thank you very much.

Form No. INTNT