Pharmacy Benefit Dimensions®
An Independent Health company

USING A MAIL-ORDER PHARMACY

In addition to Pharmacy Benefit Dimensions' (PBD) retail pharmacy network, you may also obtain 90-day supplies of maintenance medications through Wegmans Mail Order Pharmacy Services or ProAct Pharmacy Services. When using these mail-order pharmacies, your medications are shipped to you by standard delivery at no additional cost to you (express shipping is available for an additional charge).

First-time registration

Before using Wegmans Mail Order Pharmacy Services or ProAct Pharmacy Services for the first time, you will have to register with the mail-order pharmacy of your choice. Here's how to register (Please have your member ID number available):

- **By mail:** Please fill out the registration form for the mail-order pharmacy of your choice. Forms are available online in the "Members" section at www.pbdrx.com or by calling PBD's Member Services Department at the phone number located on the back of this page.
- **Online:**
  Wegmans Mail Order Pharmacy Services: www.Wegmans.com/Pharmacy
  ProAct Pharmacy Services: https://secure.proactrx.com/mail order/
- **By phone:**
  Wegmans Mail Order Pharmacy Services: 1-888-205-8573 (TTY: 1-877-409-8711)
  ProAct Pharmacy Services: 1-888-425-3301 (TTY: National 711 Relay Service)

Obtaining Prescriptions

- You will first need a new prescription written by your doctor. Please ask your doctor to write a new prescription for a 90-day supply for mail service plus refills for up to one year (as appropriate).
- **Please note:** When placing your initial order, you should have at least a 14-day supply of that medication on hand to hold you over. If you do not have enough medication, you may need to ask your doctor for another prescription for a 30-day supply to be filled at your local retail network pharmacy.
- Your copayment for your 90-day supply depends on your plan.
- You may easily pay your copayments using Visa®, MasterCard®, Discover, American Express, or by check or money order.

Ordering Refills

You can easily refill your prescription online, by telephone or by mail. You will need to have your member ID number and your prescription number when ordering refills. If you choose to pay by credit card, please have your card number available as well. To make sure you don't run out of medication, remember to reorder 14 days ahead of time.

Questions

If you have questions about the status of your mail-order prescription, please call:

Wegmans Mail Order Pharmacy Services
1-888-205-8573
TTY: 1-877-409-8711

ProAct Pharmacy Services
1-888-425-3301
TTY: National 711 Relay Service

If you have questions about your coverage and benefits, please call PBD's Member Services Department at (716) 635-7880 or 1-888-878-9172, Monday through Friday from 8 a.m. and 8 p.m. TTY users can call 1-800-432-1110

Wegmans Mail Order Pharmacy Service Sign-Up Form

- Please complete this form and mail it to: Wegmans Pharmacy Free Home Shipping
  P.O. Box 64472
  Rochester, NY 14624
- If you need assistance, please call our Mail Order Customer Service line at 1-888-205-8573.
- Once your prescription is delivered, go to www.Wegmans.com/pharmacy to set up your Wegmans pharmacy online profile.
- If you need to add more Additional Family Members or Prescriptions, please use a separate piece of paper. Please include all of the information that is requested on the form.

Cardholder Information:

First Name | MI | Last Name | Suffix | Date of Birth (MM/DD/YYYY)

Permanent Address

City | State | Zip Code

Email Address (for shipping notification) | Preferred Phone Number ( )

Check one: ○ Home ○ Cell

Cardholder ID | Group ID

Gender:
○ Male ○ Female

Drug Allergies:
○ None ○ Codeine ○ Penicillin ○ Aspirin ○ Sulfa ○ Other: _____

Additional Family Members:

First Name | MI | Last Name | Suffix | Date of Birth (MM/DD/YYYY)

Same Address as Cardholder ○

Alternate Address

City | State | Zip Code

Relationship to Cardholder:
○ Spouse ○ Child

Gender:
○ Male ○ Female

Drug Allergies:
○ None ○ Codeine ○ Penicillin ○ Aspirin ○ Sulfa ○ Other: _____

First Name | MI | Last Name | Suffix | Date of Birth (MM/DD/YYYY)

Same Address as Cardholder ○

Alternate Address

City | State | Zip Code

Relationship to Cardholder:
○ Spouse ○ Child

Gender:
○ Male ○ Female

Drug Allergies:
○ None ○ Codeine ○ Penicillin ○ Aspirin ○ Sulfa ○ Other: _____

MD Name	MD Phone #	MD Address	
	(___)___-____		
Drug Name/Strength	**Patient name**	**I will include prescription with this form**	**Please contact my doctor for this prescription**
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○
		○	○

Shipping Information:

Shipping Address (only if different than permanent address)

City **State** **Zip Code**

Payment Information

○ **Credit Card** (we accept American Express®, Discover®, MasterCard® and Visa®)

Card Type: ○ American Express® ○ Discover® ○ MasterCard® ○ Visa®

Credit Card Number **Expiration (MM/YY)**

/

Card Holder's First Name **MI** **Card Holder's Last Name** **Suffix** **Date of Birth (MM/DD/YY)**

/ /

Billing Address

City **State** **Zip Code**

By signing below, I authorize Wegmans to charge the credit card identified above for this order and all future orders associated patient(s) listed above, and that at my verbal request; Wegmans may update the cardholder name, billing address and/or credit card expiration date on file.

Cardholder Signature_____ Date:_____

PROACT
PHARMACY SERVICES

Register now to receive
Automatic Refills!

Pharmacy Benefit Dimensions
An Independent Health company

At ProAct Pharmacy Services, we want to make your life easier! With our Automatic Refill Program, you never have to worry about requesting a refill again. We can schedule your prescriptions to be automatically filled and shipped right to your door!

How does it work?
You select which medications you wish to enroll, we take care of the rest! Your prescription will be automatically refilled and shipped to you prior to running out of your current supply.

Getting started!
Getting started is easy! You can enroll in our Automatic Refill program through any of the following:

1. Register Online at www.proactpharmacyservices.com/pbd/autofill.html
2. Email – MailOrder@ProActPharmacyServices.com
3. Phone – 1-888-425-3301
4. Or return this form via Mail to - ProAct Pharmacy Services
   1226 US Highway, Route 11
   Gouverneur, NY 13642

Simply let us know which medications you would like to enroll, and we will take care of the rest.

What if your prescription changes?
Please notify us of any changes to any enrolled medications such as change in dose, directions, or discontinuation of a product to ensure obsolete orders are not automatically filled and shipped, as pharmacy regulations prohibit the return of a delivered prescription medication.

ProAct Pharmacy Services' Automatic Refill program is only for maintenance medications that you will be taking long term. The Automatic Refill program is not intended for medications requiring frequent lab testing, controlled substances, or topical applications. If you have a question on which of your medications can be enrolled, please contact us at: 1-888-425-3301

Name **Date of Birth** _____

Address **Phone (Day)** ( ) -

_____ **Email** _____

Prescriptions to Enroll _____

By completing and submitting this form, I understand that I am requesting enrollment in ProAct Pharmacy Services' Automatic Refill Program. I agree to notify ProAct Pharmacy Services of any changes that may occur to any prescription medications enrolled in this program. I understand that medications in ProAct Pharmacy Services' Automatic refill program will be shipped to my primary address on file unless otherwise indicated.

Patient's Signature _____ **Date** _____

ProAct Pharmacy Services reserves the right to discontinue this service
Visit us on the Web at www.proactpharmacyservices.com/pbd

PROACT
PHARMACY SERVICES

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Patient Profile Form

Insured Family Member

Last Name: _____ First Name: _____ M.I: DOB: _____ Sex: M / F

Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Mobile: _____ Work: _____
Drug Allergies: _____ Medical Conditions: _____

Spouse

Last Name: _____ First Name: _____ M.I: DOB: _____ Sex: M / F
Home Phone: _____ Mobile: _____ Work: _____
Drug Allergies: _____ Medical Conditions: _____

Dependent

Last Name: _____ First Name: _____ M.I: DOB: _____ Sex: M / F
Home Phone: _____ Mobile: _____ Work: _____
Drug Allergies: _____ Medical Conditions: _____

Prescriptions Enclosed (New/Refills)

Name: _____ DOB: _____ Refill #'s/New Rx: _____
Name: _____ DOB: _____ Refill #'s/New Rx: _____
Name: _____ DOB: _____ Refill #'s/New Rx: _____
Name: _____ DOB: _____ Refill #'s/New Rx: _____

Total Prescriptions Enclosed: New: _____ **Refills:** _____

Please Contact us at 1-888-425-3301 to arrange a form of payment to avoid delays in shipping your prescription orders.

Completed Forms can be returned to: **ProAct Pharmacy Services; 1226 US Hwy 11; Gouverneur, NY**

13642 Receipt of Privacy Practices

I acknowledge the receipt of the ProAct Pharmacy Services Notice of Privacy Practices

Signature of Insured Family Member _____

Printed Name of Insured _____

Date _____