If you take the same medication for months at a time, you'll often find that getting your prescription through the mail will be easier and less expensive than getting them from your local pharmacy. However, prescription mail order services should not be used for medications you need immediately (sooner than two weeks). For maintenance medications you need to start taking right away: you may ask your doctor for two prescriptions. One for a small supply to be filled at your local pharmacy for immediate use, and one for the mail service pharmacy. Remember to ask the doctor to write the mail order prescription for the maximum quantity your plan allows and for one year of refills (if the law allows). Then mail them to Postal Prescription Services following these easy steps:

1. On the front of each new prescription, print clearly:
   • The member’s name and relationship to the primary covered person (e.g., self, spouse, child).
   • The member’s ID number from the primary covered person’s plan.
2. Be sure the prescribing doctor’s name is clearly indicated.
3. Complete the order form including payment information.
4. Provide a street address for delivery. Some medications, such as narcotics and drugs requiring refrigeration are restricted from delivery to a post office box.
5. Send your prescriptions, completed order form, and a co-pay in the envelope provided. A new order form and envelope will be returned with each Postal Prescription Service delivery.

How to Order Refills
If your doctor has prescribed a refill, then Postal Prescription Service will send you a refill slip with your medication order. When you need the refill, just detach the refill slip and mail it back with your completed order form and co-pay. If you cannot locate your refill slip, list the prescription numbers and the names of the medication on the order form. The prescription number is located in the upper left-hand corner of the label on your medication container. Refills may also be ordered by phone by calling the toll-free number listed in this brochure. Please remember to have your credit card information and the prescription numbers you would like to order ready. You can also order refills through our website at www.cppsx.com.

Generic Drugs
Generic medications will be substituted for brand-name medications when available and allowed by the prescribing physician. PPS utilizes only those generic medications rated highest by the FDA.

Service & Safety
Postal Prescription Services’ registered pharmacists review each prescription for accuracy before dispensing, and perform checks to assure all prescriptions are dispensed correctly. We maintain computerized patient profiles to prevent adverse reactions with other medications you are receiving from Postal Prescription Services. Should any questions arise regarding potential adverse reactions, our pharmacists will contact your doctor or you, before dispensing the medication.

Delivery Time
Please allow two weeks for delivery from the date you mail your order. Your order will be delivered to the address you requested by United Parcel Services or first class U.S. mail. In case of emergency, prescriptions can be shipped overnight for an additional charge to you. Postal Prescription Service is open for business Monday through Friday 8:00 a.m. to 6:00 p.m. and Saturday 9:00 a.m. to 12:00 p.m., Pacific Time.
**Non-Safety Cap Request Information:**

Federal law requires that your prescription shall be dispensed in a container with a child resistant or safety cap unless you request otherwise. If you would like your prescription with an "easy-open" lid please sign below. I do not want safety caps.

**Method of Payment:**
- [ ] Check
- [ ] Money Order
- [ ] Visa/MasterCard
- [ ] Discover
- [ ] Am. Express

*Make check or money order payable to:*

<table>
<thead>
<tr>
<th>Quadruplets Prescription No.</th>
<th>Name of Medication</th>
<th>Strength</th>
<th>Pharmacy Name</th>
<th>Pharmacy Phone</th>
<th>Doctor’s Name &amp; Phone</th>
<th>Price or Co-Pay</th>
</tr>
</thead>
</table>

**Total: $**

**Drugs Allergies / Health Conditions**
- [ ] None
- [ ] Codeine
- [ ] Penicillin
- [ ] Sulfa
- [ ] Aspirin
- [ ] Other
- [ ] Asthma
- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] Heart Disease
- [ ] Hyperlipidemia
- [ ] Other

**Date I mailed my order: **

**Co-pay Amount Enclosed: $**

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**Ship To This Address**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
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<table>
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<table>
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<table>
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<table>
<thead>
<tr>
<th>Day Phone</th>
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**Thank You. We appreciate your business!**

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**Health Care Plan Information**

**Health Care Plan:**

**Employer Name (if applicable):**

**Insured's D. Number:**

**Insured's Name:**

If possible, please enclose a copy of your insurance card when placing your initial order or when changing insurance.

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**Tear here, insert order form in envelope and seal.**