MAXOR PHARMACIES

Call Us Toll Free At
(800) 687-8629
or (806) 324-5500
Monday - Friday 8 a.m. to 7 p.m. CST

MAIL ORDER FORM

Mail your order to:
PO Box 32050
Amarillo, TX 79120

1 PATIENT INFORMATION

Member ID: _____
Group: _____
Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____

❑ Check here if this is a new address or phone number.
Maxor will keep this address on file for all orders filled on this account until another address is provided.

For address changes, please call Maxor Mail Order at (800) 687-8629.

E-mail Address: _____
Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐
Sex: ❑ Male ❑ Female
D.O.B.: ☐☐ - ☐☐ - ☐☐☐☐
Relationship to Cardholder:
❑ Self ❑ Spouse ❑ Child

Secondary Insurance: _____
If applicable
Group Number: _____
Name on Policy: _____
Member Number: _____

2 DRUG ALLERGIES & CHRONIC ILLNESSES

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

Severity of Drug Allergies: ❑ Mild ❑ Moderate ❑ Severe ❑ Intolerance ❑ Anaphylaxis

Chronic Illnesses: (Disease States)
❑ Thyroid ❑ High Blood Pressure ❑ Diabetes ❑ Glaucoma
❑ Heart Condition ❑ Intestinal Disorders ❑ Lung Condition ❑ Other _____

3 GENERIC MEDICATION INFORMATION

❑ I authorize Maxor Pharmacy to always[1] dispense a generic medication for me with the lowest co-payment when one is available.
[1]*Please write brand-name only medication exceptions in the space provided on the reverse side of this form.*

❑ I do not authorize Maxor Pharmacy to always[2] dispense generic medications for me with the lowest co-payment when one is available, and I understand that generic refusal may impact my co-payment.
[2]*Please refer to the reverse side of this form for further details.*

4 PAYMENT METHOD

In order to process your prescriptions quickly, please enclose the correct co-payment amount(s). If assistance is needed with calculating co-payment amount(s), please call MaxorPlus at (800) 687-0707.

Payment Options: ❑ Check/Money Order ❑ Credit Card

Paying By Credit Card? ❑ Visa ❑ MasterCard ❑ Discover ❑ American Express

Credit Card Number:
☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration Date:
☐☐ ☐☐☐☐ MM/YYYY

X _____
Signature of Cardholder

❑ I authorize Maxor Pharmacy to charge this card for all orders from any person on this account.

❑ Check here to decline keeping credit card information on file at the pharmacy.

Expedited Shipping via UPS or FedEx: ❑ **$25.00 for overnight shipping** ❑ **$15.00 for 2-day shipping**
Note: Expedited shipping will **not** rush prescription processing. Prices subject to change.

Refill your prescription on reverse side.

5 ORDER REFILLS

Brand-Name Only Medication Exceptions:				
Rx Number	Name of Medication	Strength	Doctor's Name	Co-payment

Order Refill Prescriptions Here:				
Rx Number	Name of Medication	Strength	Doctor's Name	Co-payment

Questions?

Call Maxor Pharmacy toll-free at (800) 687-8629, Monday - Friday, 8 a.m. to 7 p.m. CST.

6 HOW TO ORDER

FIRST TIME ORDERS

For NEW prescriptions or first time orders, complete the Patient Information and Payment Method sections. Write your member identification number on the back of all original prescriptions and mail to Maxor Mail Order Pharmacy. This number can be found on your member identification card.

HOW TO ORDER REFILLS

BY MAIL: Complete the Patient Information, Payment Method, and Order Refill sections and mail to Maxor Mail Order Pharmacy.

BY PHONE: Call toll free (800) 687-8629 or (806) 324-5500 and use our automated system to enter the Rx number printed on your prescription label, or speak to a customer service representative during normal business hours.

BY INTERNET: You may refill your prescriptions on our website at www.maxor.com. Please choose the REFILL PRESCRIPTIONS section under FILLING YOUR PRESCRIPTIONS. You will need your prescription numbers and credit card information available.

7 IMPORTANT IMFORMATION

[2] The submission of this form, for you or any of your dependents, authorizes the release of all information to the Plan Sponsor, Administrator, or Underwriter, and authorizes the prescription to be filled with the generic equivalent when available and permissable by law, in accordance with your benefit plan requirements. If you request a brand name drug when your doctor permits substitution, you may be responsible for paying the difference in cost between the brand and generic medication plus the brand co-pay. Refer to your plan benefit information booklet for more details.

Please Note:
If your prescription refill label says "NO REFILL AUTHORIZED," please contact your doctor and request a new written prescription.

Reminder: You will always be charged the mail order co-pay when you send or transfer a prescription to Maxor Mail Order Pharmacy. To maximize your savings, ask your doctor for a 90 day supply with refills up to one year.

Written information about this prescription has been provided for you. Please read this information before you take this medication. If you have questions concerning this prescription, a pharmacist is available during normal business hours to answer your questions. Please call your pharmacy.

Complaints against the practice of pharmacy may be filed with the:

Texas State Board of Pharmacy
William P. Hobby Building, Suite 3-600
333 Guadalupe, Box 21
Austin, Texas 78701-3942 • (512) 305-8000
To receive a complaint form call
(800) 821-3205 or (512) 305-8080 if in Austin.
(recorded information only)
www.tsbp.state.tx.us

Se la presentado a usted la informacion por escrito sobre esta receta. Favor de leer esta informacion antes do tomar el medicamento. Si usted tiene preguntas tocante a esta receta, estara un farmaceutico disponible durante las horas de negocio para contestar sus preguntas. Por favor llame a su pharmacia.

Quejas contra la practica de la farmacia pueden ser reportadas al:

Concilio de Farmacia Del Estado De Tejas
William P. Hobby Building, Suite 3-600
333 Guadalupe, Box 21
Austin, Texas 78701-3942 • (512) 305-8000
Para recibir una forma de queja llame:
(800) 821-3205 or (512) 305-8080 if in Austin.
(informacion grabada solamente)
www.tsbp.state.tx.us

This form is used to order refills or new prescriptions. Please mail this form 14 days in advance before your medication runs out and enclose the appropriate co-payment amount.