# Home Delivery Registration Form

**CastiaRx Medicare Part D Members**

**Welcome to CastiaRx Home Delivery!** Follow the four steps on this form and you'll be registered for home delivery of your maintenance medications, which can save you time and money.

## 1. Provide your background information

### Patient Information

FIRST NAME _____ LAST NAME _____

GROUP NUMBER _____ MEMBER ID _____

☐ Male
☐ Female

DATE OF BIRTH _____ PHONE NUMBER _____

SHIPPING ADDRESS _____ CITY _____

STATE _____ ZIP _____ EMAIL _____ ALTERNATE PHONE NUMBER _____

### Prescription and Prescriber Information

CastiaRx will contact your prescriber for a new 90-day prescription

| Medication Name & Strength | Prescriber Name | Prescriber Phone Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

☐ I have questions regarding my medication(s) and would like a pharmacist to call me

## Questions?

Call **866-516-1121** // TTY **866-706-4757**
Visit **CastiaRx.com**

Form continues >

## 1. Background information (continued)

**Allergies**

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfonamide
- ☐ None
- ☐ Other: _____

**Health Conditions**

- ☐ Arthritis
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Intestinal Disorder(s)
- ☐ Lung Condition
- ☐ Thyroid
- ☐ Other: _____

## 2. Provide your payment information

You may pay with a major credit/debit card, electronic check, check or money order. Payment must be received before an order is shipped. To simplify the refill process, authorize CastiaRx Pharmacy to keep your credit/debit card on file.

- ☐ Credit/Debit Card
- ☐ FSA/HSA Card
- ☐ Electronic Check*
- ☐ Check/Money Order*

- ☐ Authorize this card to remain on file for all future payments
- ☐ Call me to authorize this card before filling each order

*A representative will contact you with your total, please don't send any payment with this form

I understand that applicable prescription costs will be charged by CastiaRx Pharmacy to the credit card provided. I also understand by signing this form that prescription medications cannot be returned to the pharmacy for credit unless in response to a recall, defect in a medical device, or otherwise pre-approved by the pharmacy. A medication return for any reason will result in its immediate destruction and shall not be available for credit.

CARD NUMBER _____ CVV CODE _____

NAME (as it appears on card) _____ EXPIRATION DATE _____

BILLING ADDRESS (if different from shipping) _____

CARDHOLDER SIGNATURE _____ DATE _____

## 3. Check your work and authorize

I certify that the patient information entered on this form is correct and that the patient named is eligible for benefits under the prescription drug program and authorize the release of all information to the plan administrator. The information on this form will remain private, and will be used to fill your prescriptions and monitor for any harmful drug/disease interactions. I authorize the release of any medical information required to process this claim.

SIGNATURE (required to process order) _____ DATE OF SIGNATURE _____

## 4. Submit this form

**Registration forms may be submitted by:**

**Mail:** CastiaRx Pharmacy
701 Emerson Road, Suite 301
Creve Coeur, MO 63141

**Fax:** 877-649-1910

**Email:** HomeDelivery@CastiaRx.com

CastiaRx will contact your prescriber for a 90-day prescription, or you can have your prescriber send a 90-day prescription via **ePrescribe** (NABP# 2611590, NPI# 1285737411), **fax** or **mail**. We are unable to accept prescriptions via email.

## Have a new prescription that you need filled?

If it's your first time using CastiaRx Home Delivery, complete and submit this registration form. If you're already enrolled, have your prescriber submit your prescription by:

**ePrescribe** to CastiaRx, NABP#: 2611590, NPI#: 1285737411.

**Fax** to CastiaRx at 877-649-1910. It must include a fax cover sheet from the prescriber's office.

**Mailing** the original prescription to CastiaRx Pharmacy, 701 Emerson Road, Suite 301, Creve Coeur, MO 63141.

Your prescriber must write the prescription for a 90-day supply and show the exact quantity to be dispensed.

**If you ever have a question about your medications, shipments or billing, our support specialists are available by phone.**

Call **866-516-1121** // TTY **866-706-4757**

ATTENTION: CastiaRx complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. If you speak another language, language assistance services, free of charge, are available to you. Call 1-866-516-1121 (TTY: 1-866-706-4757).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-516-1121 (TTY: 1-866-706-4757). // CastiaRx cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-516-1121（TTY：1-866-706-4757）。 // CastiaRx 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。