



# **NoviXus**

## **Pharmacy Services**

Enrollment as Simple as 1-2-3!

This Mail Service Enrollment Form is only necessary for:

- first time orders.
- including dependents who have been added since the last order,
- or changes to current information.

**To start your Mail Service Benefit, follow these steps:**

### ***Step 1: Enroll***

Complete the mail order enrollment form.

### ***Step 2: Fill Your Prescription***

Mail the original prescription to Novixus with your enrollment form, or have your health care provider send the prescription directly to Novixus. Your provider can send the prescription to Novixus through the following options:

- Call: 1-888-240-2211
- E-prescribe
- Fax: 1-877-395-4836
- Mail: PO Box 8004, Novi, MI 48376

Please print your member ID on each prescription.

### ***Step 3: Complete Payment***

Make your copayment by phone at 1-888-240-2211 or by mail. Novixus accepts major credit cards or checks.



# Mail Order Enrollment Form

## How to Order New Medication

**Step 1: Enroll**—Complete the mail order enrollment form.

**Step 2: Fill Your Prescription** — Mail the original prescription to Novixus with your enrollment form, or have your health care provider send the prescription directly to Novixus. Your provider can send the prescription to Novixus through the following options:

- Call: 1-888-240-2211.
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- Fax: 1-877-395-4836
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Please print your member ID on each prescription.

**Step 3: Complete Payment**—Make your copayment by phone at 1-888-240-2211 or by mail. Novixus accepts major credit cards or checks.

## Quality

Your prescription order will be shipped using US Mail. Some items may be shipped by expedited courier. Refrigerated items are shipped in accordance with FDA and manufacturers specifications. For your security, some controlled substances may require a signature.

## How to Order Refills

Refills can be ordered using any of the following methods:

ONLINE [www.novixus.com](http://www.novixus.com)  
CALL 1-888-240-2211, 24-7

Refill orders should be placed three weeks prior to when the medication will be needed.

Prescriptions cannot legally be mailed from a mail order pharmacy (or any other pharmacy operating within the United States) to locations outside of the United States, with the exception of U.S. territories, protectorates and military installations.

## Generic Medications

Where appropriate, Novixus uses generic medications to fill your prescriptions. The FDA requires that all drugs be safe and effective. Since generics use the same active ingredients and are shown to work the same way in the body, they have the same risks and benefits as their brand name counterparts.

## Novixus Will Contact Your Prescriber for New Prescriptions

Complete this section only if requesting new mail order prescriptions from your prescriber.

We substitute generics on prescriptions unless otherwise noted by your doctor.

Patient Name	Date of Birth	Medication Name and Strength	Prescriber's Name, Phone Number and Fax Number

Once Novixus has received all necessary and correct information, please allow 2 weeks for prescription order delivery.

# NoviXus Mail Order Enrollment Form

Please complete and mail this form with all prescriptions. Please print or type. **Please list all insurance applicable.**

\_\_\_\_\_  
 Last Name                      First Name                      M.I.                      Date of Birth

\_\_\_\_\_  
 Home Address                      City                      State                      ZIP

\_\_\_\_\_  
 Shipping/Billing Address\*                      City                      State                      ZIP

\*If Shipping and Billing Addresses are different, please provide both addresses.

\_\_\_\_\_  
 Primary Phone                      Secondary Phone

\_\_\_\_\_  
 E-mail Address

\_\_\_\_\_  
 Group Name (Primary)                      Group ID#                      Member ID#

\_\_\_\_\_  
 Group Name (Secondary)                      Group ID#                      Member ID#

## BILLING INFORMATION

**Check Enclosed:**

**Please Charge My:**  Visa     Master Card  
 Discover     Am. Express

\_\_\_\_\_  
**Credit Card\* #:**

\_\_\_\_\_  
**Expiration Date:**

\_\_\_\_\_  
**Cardholder's Name:**

\_\_\_\_\_  
**Signature:**

\*Credit Card Will Be Used For All Future Orders

**Acknowledgement:** I understand that when permitted by law, Novixus will substitute an FDA approved generic equivalent drug for any brand-name medications enclosed with this order unless specified by the Plan or prohibited by me or the prescriber in writing. For all prescriptions submitted, I certify that I or my family members are eligible to receive prescriptions under this plan. I will take personal responsibility for payment of all medications that I or my family members receive.

MEMBER INFORMATION					DRUG ALLERGIES											
Family Member Name	ID Number	Date of Birth	Relationship to Subscriber	Gender (M/F)	*Please enclose additional family member information, such as drug allergies, on another piece of paper.											
					None	Ampicillin	Aspirin	Cephalosporins	Codeine	Erythromycin	Penicillin	Sulfa	Tetracyclines	Other* (Please Specify)		

Check here if you want Easy Open Caps.  
*Child proof caps are used for safety in shipping.*

**Please print member ID on each prescription.**

**If transferring prescriptions from another pharmacy, please include the following information on a separate sheet of paper. Member Name, Date of Birth, Medication Name and Strength, Prescriber Name and Phone Number.**

Once Novixus has received all necessary and correct information, please allow 2 weeks for prescription order delivery.

\_\_\_\_\_  
 Signature

If you have questions, please contact Novixus Customer Service at 1-888-240-2211.