Home Delivery Registration Form

Welcome to CastiaRx Home Delivery! Follow the four steps on the front and back of 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 _____

MEMBER ID _____ DATE OF BIRTH _____

☐ Male ☐ Female

☐ Patient is a dependent

CARDHOLDER NAME _____ PRIMARY 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

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: _____

*CastiaRx will send you shipping information and may choose to communicate with you via email. We value your privacy – personal information will be kept confidential and will never be sold to third parties.

Questions? Call **866.516.1121** or visit **CastiaRx.com**

Form continues on back >

2. Provide your payment information

Method of Payment

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 rep 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

CARDHOLDER SIGNATURE

BILLING ADDRESS
(if different from shipping)

3. Check your work and authorize

Make sure the information on this form is correct

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:

Fax: 877.649.1910 // Email: HomeDelivery@CastiaRx.com // Mail: CastiaRx, 701 Emerson Road, Suite 301, Creve Coeur, MO 63141

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

If you ever have a question about your medications, shipments or billing, our support specialists are available by phone. **Call 866.516.1121**

You can request refills or enroll in our auto refill program online. **Visit CastiaRx.com/members**