Patient Profile Form

Aetna Specialty Pharmacy®
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-782-ASRX (1-866-782-2779)

Simply follow these easy steps to start using Aetna Specialty Pharmacy:

New Prescriptions

- Complete Sections A, B, C and D of this form.
- Print your name, address, date of birth and member ID number on each prescription.

Mail this completed form with your prescription(s) and method of payment to:

Attn: Pharmacy Operations
Aetna Specialty Pharmacy
503 Sunport Lane
Orlando, FL 32809

Refills of Existing Prescriptions:

It is not necessary to submit this form to request a refill. One week before your next refill is due, we will call you to schedule your delivery. During this call, we will coordinate your home health care, if needed. We will also ask:

- How you are doing with your therapy
- If you are still taking the same medication
- If you are still taking the same dose
- If you are having any side effects
- If you need additional supplies
- Where you would like your next refill delivered.

SECTION A - PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
Ship Meds to: ☐ Home ☐ Work	☐ Doctor's Office	Height:	Weight:

Have you had a transplant? ☐ Yes ☐ No
If Yes: Date of Transplant: ____________________
Organ transplanted: ____________________

Where did the transplant take place?
Facility Name: ____________________
Facility City: ____________________ State __________ ZIP: __________

Allergies:	Health Conditions:

SECTION B - INSURANCE INFORMATION

Primary Insurance:		**Pharmacy Benefit Manager (PBM)**:	
Policy #:	Group #:	Insured:	Phone:

Do you have Medicare Part(s) A, B, C or D? ☐ Yes ☐ No If Yes, check all that apply below and provide number(s).
☐ Medicare A: ☐ Medicare B: ☐ Medicare C: ☐ Medicare D:

Do you have Medicaid? ☐ Yes ☐ No
If Yes, provide #: ____________________

* **Note:** If your medication is covered by the Medicare Part B benefit, Medicare guidelines state that you will receive the standard 30-day supply, your medication must ship to your home, and someone must sign for the package upon delivery.

Secondary Insurance:			
Policy #:	Group #:	Insured:	Phone:

SECTION C - PHYSICIAN INFORMATION

First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP:
Phone:	Fax:	Office Contact Name:	Phone:	

SECTION D - PAYMENT INFORMATION

To estimate the cost of your medications, visit **www.aetna.com** and log in to AetnaNavigator®. Look for the "Take Action on Your Health" tab, then select "Cost of Care." The cost of your medication can be found on the "Prescription Drugs" link. You may also call the toll-free number on your Aetna member ID card for medication cost information.

Method of Payment: After you submit this completed form with your prescription(s), we will call you to confirm your delivery and the payment amount due. Make a check or money order payable to Aetna Specialty Pharmacy or use your personal credit or debit card. Do not send cash.
Important Information:

- If you do not include a method of payment with your order and a previous order was paid for by credit or debit card, we will use that credit or debit card as the method of payment for this order.
- If you have an unpaid balance with our pharmacy this order may not be processed until payment is received.
- If you have a Flexible Spending Account (FSA) auto-debit feature, or are enrolled in an Aetna HealthFund® or Vital Savings on Health℠ plan, please provide a personal credit or debit card to cover any expenses that may exceed your account balance.
- If you are enrolled in an FSA, Health Savings Account (HSA) or Vital Savings on Health program and have a FSA/HSA/Vital Savings on Health debit card, you can use that card for payment. (Please also provide a personal credit or debit card to cover any expenses in excess of your account balance.)
- Providing a credit or debit card will help prevent delays in order processing that result from insufficient payment.

MC/VISA/Amex/Discover or debit card number	**Expiration Date**
FSA/HSA debit card number	**Expiration Date**
Cardholder Name	**Signature**

The credit and/or debit cards used in processing this order will be billed for medication order costs, rush shipping costs (if applicable) and any outstanding balances. They will also be billed for all future orders unless your provide another method of payment.

For more information about Aetna Specialty Pharmacy, please visit **www.AetnaSpecialtyRx.com**.

GR-68522 (5-09)