Department of Veterans Affairs

Meds by Mail Order Form

A mail order prescription service for qualified Camp Lejeune Family Member Program

This form is for Prescription Orders Only

Important Information

- ***This form must be filled out completely including your Social Security number and Date of Birth for identification purposes. If you cannot be identified, your prescription will not be filled.***
- This form is to be completed by the patient, family member, or caregiver with power of attorney.
- Use a separate form for each patient or family member.
- This order form is required **EVERY TIME** a written prescription from your medical provider is mailed.
- Attach the original prescription to this form. Photocopies of prescriptions are not accepted.
- Your medication delivery may take up to **21 days** from the date you mail your order. To ensure that you have enough medication to last until your shipment arrives, you may need to request a second written prescription from your medical provider that can be filled at your local pharmacy.
- This mail order service is provided only for maintenance medication—that is, medications that are required for extended periods of time. All short-term or one-time-use prescriptions must be obtained at your local pharmacy. Meds by Mail primarily dispenses generic medications; if you need a brand name product when a generic is available you will have to use your retail pharmacy.

How to Request Prescription *REFILLS:*

This form is for use when you send a **paper prescription** written by your medical provider. Refill orders should be placed by calling our automated refill system. Simply call 1-888-370-1699 and follow the voice prompts. Refill orders may also be placed using the refill slip that accompanies each shipment of medication. If you choose to reorder by mail, be sure to return your refill slip as soon as you receive your prescription order, as it may take up to **21 days** to process your order. **DO NOT DELAY** in requesting your refills. Read the refill slip carefully, it contains information you will need concerning the number of refills remaining and the prescription expiration date.

Privacy Act Information and Paperwork Reduction Act Notice

The information requested on this form is solicited under the authority of 38 C.F.R. §17.32. It is being collected to document your preferences for your health care in the event that you can't speak for yourself anymore. The information you provide may be disclosed outside the VA as permitted by law. Possible disclosures include those that are described in the "routine uses" identified in the VA system of records 24VA19, Patient Medical Record-VA, published in the Federal Register in accordance with the Privacy Act of 1974. This is also available in the Compilation of Privacy Act Issuances at http://www.gpoaccess.gov/privacyact/index.html. You may choose to fill out this form or not. But without this information, VA health care providers may not understand your preferences as well. If you don't fill out this form, there won't be any effect on the benefits you are entitled to receive. The Paperwork Reduction Act of 1995 requires us to let you know that this information collection follows the clearance requirements of section 3507 of this Act. We estimate that it will take you about 5 minutes to fill out this form, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information you write down. A Federal agency may not conduct or sponsor, and a person is not required to respond to a collection of information, unless it displays a current valid OMB control number. The OMB Control No. for this information collection is 2900-XXXX.

Where to Mail your Prescriptions:	
WEST If you live in one of the following states or territories, mail your order form to the address listed below: Alaska, American Samoa, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, N. Mariana Island Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wisconsin, Wyoming.	**EAST** If you live in one of the following districts, states or territories, mail your order form to the address listed below: Alabama, Connecticut, Delaware, Florida, Georgia, Guam, Kentucky, Maine, Maryland, Massachusetts, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Virgin Islands, Washington D.C., West Virginia.
Telephone: 1-888-385-0235 **Address:** Meds by Mail PO Box 20330 Cheyenne, WY 82003-7008	**Telephone:** 1-866-229-7389 **Address:** Meds by Mail PO Box 9000 Dublin, GA 31040-9000

Camp Lejeune Family Member Program

Patient Prescription Information. This form must be filled out completely.

Patient Name: (Last, First, Middle Initial)	Patient SSN	Date of Birth (mm-dd-yyyy)

MAILING INFORMATION

Patient Mailing Address:	Daytime Phone Number (Including Area Code):
	Home:
	Cell:

Is this a change of address? ☐ Yes ☐ No

Is this a permanent change? ☐ Yes ☐ No

Is this a temporary change? ☐ Yes ☐ No

(A temporary address will not affect your permanent address, only where your meds are being mailed. A temporary address will not change until you notify Meds by Mail.)

NON-SAFETY CAP REQUEST:

Federal law requires that your medication be dispensed in a container with a child resistant or safety cap. If you would like your prescription with an "Easy-Open" lid, **please sign below**:

Signature: _____ Date: _____

Medication Allergies

- ☐ None
- ☐ Aspirin
- ☐ Cephalosporins
- ☐ Codeine
- ☐ Erythromycin
- ☐ Other (specify below)
- ☐ Morphine
- ☐ NSAID (ex. Ibuprofen)
- ☐ Penicillin (ex. Ampicillin)
- ☐ Sulfa (ex. Bactrim, Septra)
- ☐ Tetracycline (ex. Minocycline)
- ☐ Food Allergy (specify below)

Health Conditions

- ☐ Bladder cancer
- ☐ Breast cancer
- ☐ Esophageal cancer
- ☐ Kidney cancer
- ☐ Lung cancer
- ☐ Scleroderma
- ☐ Leukemia
- ☐ Multiple myeloma
- ☐ Other (specify below)
- ☐ Myelodysplastic syndrome
- ☐ Non-Hodgkin's lymphoma
- ☐ Hepatic steatosis
- ☐ Renal toxicity
- ☐ Neurobehavioral effects
- ☐ Female infertility
- ☐ Miscarriage

	Medication Name	Name of Medical Provider Who Signed the Prescription
1		
2		
3		
4		
5		
6		
7		
8		