

PRESCRIPTION MART

Custom care, done right.

MAIL ORDER PHARMACY

HOW TO GET STARTED

Taking advantage of your mail order benefit may enable you to receive up to a 90-day supply of your maintenance medication(s). Just ask your physician to write for a 90-day supply, plus additional refills (to be filled at Prescription Mart).

Online: Log onto myempirxhealth.com where you will be prompted to create a Prescription Mart Mail Order account. If you choose to create one later, you can click on the banner at the top of each page to create an account. Prescription Mart cannot fill your order until you have registered.

E-prescribe or Fax: Have your doctor e-prescribe to Prescription Mart or fax your prescription to 1-409-866-1317. Faxed prescriptions may only be sent by a doctor's office and must include patient information and diagnosis for timely processing.

Mail: Mail your 90-day prescription and completed Patient Profile and Medication Order Form with payment to PO Box 12607, Beaumont, TX 77726.

GETTING A REFILL IS EASY

Online: Log onto myempirxhealth.com, then go to the Prescription tab to order refills.

Mail: Print an order form from our website and mail to PO Box 12607, Beaumont, TX 77726.

Phone: Call us at 1-877-651-3392 with your prescription number and payment information.

CONTACT US

Toll-free Phone:

1-877-651-3392

Fax:

1-409-866-1317

Customer Service:

Mon-Fri: 8a-8p EST

Sat: 9a-6p EST

(Closed major holidays)

Website:

prescriptionmartpharmacy.com

Mailing Address:

Prescription Mart

PO Box 12607

Beaumont, TX 77726

FREQUENTLY ASKED QUESTIONS

When will I receive my medication?

Shipping may take up to 14 days. In some cases, we utilize a combination of mail-order partners for expedited service. Shipping is generally free unless you want your prescription sooner or have special handling needs.

What if my medications require special handling?

If your medications need refrigeration/special handling, a team member will contact you.

How will you contact me?

We use text, email and a standard toll-free telephone number.

How do I pay for my prescriptions?

We do require payment before we ship your order (we do not bill). You can pay by personal check, money order, FSA/HSA or major credit/debit card. Please **don't** send cash.

How are controlled substances handled?

These prescriptions have strict guidelines. Our team will reach out to you to confirm additional details.



Find our Notice of Privacy Practices at prescriptionmartpharmacy.com

Translation Services are available for limited English proficiency patients upon request.

Prescription Readers are available for visually impaired patients upon request.

EMPIRX HEALTH

NEW PRESCRIPTIONS – Mail your new prescriptions with this form.

Number of **NEW** prescriptions enclosed _____

REFILLS – Indicate the prescriptions to be refilled in **Section 3**.

Number of **REFILL** prescriptions requested _____

1 INSURANCE INFORMATION		
Identification Number:	Group #:	RxBIN #:
Cardholder's Employer:		
If your prescriptions will be filed under workers' compensation, please provide your injury date: MM / DD / YYYY		
2 PATIENT INFORMATION ☐ Check for Spanish		
Patient Name: First Middle Initial Last Suffix (JR, SR)		
Date of Birth: Month / Day / Year	☐ Male ☐ Female	☐ Check here for Easy Open caps
Home Address: Street Address Apt./Suite #		
City:	State:	Zip Code:
Daytime Phone #: () -	Alternate Phone #: () -	
Cell Phone #: () -	☐ Check to receive text notifications & alerts	
Email address:	☐ Check to receive email notifications & alerts	
Doctor's Name:	Doctor's Phone #: () -	
Please complete the following medical information if you are a new patient or information has changed :		
Drug Allergies: ☐ None ☐ Aspirin ☐ Cephalosporin ☐ Codeine ☐ Erythromycin ☐ Latex ☐ NSAIDs ☐ Peanuts ☐ Penicillin ☐ Sulfa ☐ Other: _____		
Medical Conditions: ☐ None ☐ Acid Reflux ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Depression ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Migraines ☐ Osteoporosis ☐ Prostate ☐ Thyroid ☐ Other: _____		
List other medications you take not filled by Prescription Mart (including over the counter supplements):		
Prescription Mart may substitute FDA-approved generic medications for brand name medications unless you or your prescriber specify otherwise. If you DO NOT want generic medications, you must provide specific instructions (including drug names) below. Refusal of generics may impact your copay.		
3 PRESCRIPTION REFILL INFORMATION		
To request prescription Refills, write the Rx Number and medication name below.		
1.	2.	
3.	4.	
5.	6.	
7.	8.	
4 PAYMENT INFORMATION AMOUNT AUTHORIZED: \$ _____		
If your copay is \$0, you do not need to provide payment information.		
☐ Call me for payment information		
☐ Check or money order enclosed (Payable to: Prescription Mart). Write your Member ID # on your check. Prescription Mart may charge up to \$25 for returned checks.		
☐ Charge credit card on file		
☐ Apply credit balance to this order		
☐ Please charge the following card:		
☐ Visa ☐ Mastercard ☐ Discover ☐ American Express		
Credit card number: _____		
Expiration Date: _____ Billing Zip Code: _____		
Name as it appears on card: _____		
☐ Keep this payment method on file for future orders ☐ Use this payment method one time only		
DO NOT SEND CASH.		
CREDIT CARD HOLDER SIGNATURE: _____ DATE: _____		
5 SHIPPING ADDRESS (if different from Home Address listed in Section 2)		
First Name Middle Initial Last Name		
Company Name (if applicable)		
Street Address		
City	State	Zip Code
☐ Check here if you would like us to use this shipping address <u>for this order only</u> and not future orders.		
☐ Check here if you would like us to contact you to schedule expedited shipping at your expense.		
If your medication(s) require special handling, a team member will reach out to you to advise when delivery is expected.		
6 CERTIFICATION		
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. I hereby assign to the provider pharmacy any payment due pursuant to this transaction and future transactions and authorize payment directly to the provider pharmacy. I also authorize release of all information pertaining to the claim to the plan administrator, underwriter, sponsor, policy holder and employer in accordance with the Health Insurance Portability and Accountability Act (HIPAA).		
PATIENT SIGNATURE: _____ DATE: _____		