Integrated HMO Pharmacy

How do I start?

For your first order, we require that you fill out the Integrated HMO Pharmacy Order Form and include the original prescriptions from your doctor. This initial order form must include information about you, including current medications, any known drug allergies, and chronic medical conditions. This will allow us to monitor any potential drug interactions. Please note that payment is required at the time a prescription is ordered. If you have questions, simply call 1-800-633-7928.

How do I order refills?

You should order refills when you have around 14 - 21 days supply left, and although it usually does not take this long, it serves as a safety net so you do not run out of medicine. You may call 1-800-633-7928, you may fill out the order form that is enclosed with each order you receive, or you may order your refills from our website at http://ihmo.pti-nps.com. Please remember to include payment with your refill order to avoid possible delays in processing your prescription order. Your order will be sent via United Parcel Service (UPS) or U.S. Postal Service.

What kind of prescriptions can I receive from mail order?

The types of prescription medication that can be ordered through the mail is medicine that you will be on for more than 1 month in a row (maintenance medication) and that you expect no changes to be made in the dosing or dosing schedule. Any medication that you will need immediately (emergency supply) should not be ordered through our mail order pharmacy. Some examples of medications that should not be ordered through mail order are an antibiotic for an ear infection or pain medication for a broken arm.

Your prescription drugs are conveniently mailed to the safety, and security of your own home or work with ***no additional charges*** for standard delivery. Integrated HMO Pharmacy's staff is professional and courteous and willing to go above and beyond to meet your pharmaceutical needs. We want to be ***your mail order pharmacy***.

Integrated HMO Pharmacy

Your Mail Order Pharmacy is Committed to Serving You

Quantities to be dispensed

Please have your physician write your prescription for a 3 month or a 90 day supply, if possible. The prescription must display the quantity that you and your physician want to be dispensed by our facility (i.e. a prescription written for 1 tablet a day for a quantity of 30 tablets with 2 refills will be filled for 30 tablets only, not a 3 month supply.) We will not dispense any amount greater than the exact amount written by your doctor or the day supply limit specified by your plan.

Generic utilization

Whenever appropriate and safe, generic drugs will be used to fill prescriptions, unless otherwise specified by your physician or your plan. If you prefer the name brand, you simply pay the difference between the brand name price and the generic price, plus the copayment fee.

If I have other questions

You are always welcome to call us with any questions you have, whether about medications, shipments, or account information at **1-800-633-7928**. Please call us! You are welcome to give this number to your physicians and have them call your prescriptions in to the pharmacists at Integrated HMO Pharmacy.

Integrated HMO Pharmacy
PO Box 369
Boys Town, NE 68010
www.pti-nps.com

P 402|965|8035 • TF 800|633|7928
F 402|493|2707 • TFF 800|801|2395
TTY users should call: 866|706|4757

Integrated HMO Pharmacy

Your Mail Order Pharmacy
1-800-633-7928

A CONVENIENT WAY TO HAVE YOUR PRESCRIPTIONS DELIVERED TO YOUR DOOR

Integrated HMO Pharmacy provides a ***simple and convenient*** way for you to order your prescriptions through the mail. No more standing in line. No more fighting for parking spots.

Your Mail Order Pharmacy
1-800-633-7928

AT A GLANCE

- Complete the order form.
- Please include the following information:
  - *Identification number*
  - *Your full name*
  - *Complete street address*
  - *Telephone number*
  - *Your date of birth*
  - *Doctor's name*
  - *Doctor's phone number*
  - *Your signature on form*
- Enclose prescriptions or print the Integrated HMO Pharmacy refill prescription number on form
- Mail to:
  Integrated HMO Pharmacy
  P.O. Box 369, Boys Town, NE 68010
- Please include check, money order or credit card information. We also accept VISA, MASTERCARD, or DISCOVER. (No Debit/Bank cards)
  Payment is due at the time a prescription is ordered. PLEASE DO NOT SEND CASH.
- To avoid delays in processing your prescriptions, please be sure to include payment with your order.
- Please attach additional information if necessary.
- Please reorder refills 14 - 21 days before you run out of medicine by calling **1-800-633-7928** or through our website: **www.pti-nps.com**

ORDER FORM FOR NEW PRESCRIPTIONS AND REFILLS

Information

Identification Number | Plan Name | Plan Number (if known)

Last Name | First Name | Initial

Ship to this address

☐ ***Please check here if this is a change of address.***

Street Address (No P.O. Boxes Please) | Apt. or Suite | City

State | Zip Code | Home Phone Number | Work Phone Number

Patient Information

Last Name | First Name | Initial | Birthday | Sex ☐ Male ☐ Female | ☐ ***Please, no child-proof caps***

Physician Information

Last Name | First Name | Initial | Physician's Phone Number

☐ **Check here if you DO NOT wish to use a generic product.**
If you check the above box, you may be required to pay a higher copayment or your product choice may not be covered by your prescription plan, depending on your plan design. Please refer to your benefit materials for details.

Drug Allergies:
☐ Aspirin ☐ Penicillin
☐ Codeine ☐ None
☐ Sulfonamides ☐ Other _____

Health Conditions (to monitor drug/disease interactions)
☐ Arthritis ☐ High Blood Pressure
☐ Diabetes ☐ Intestinal Disorders
☐ Glaucoma ☐ Lung Condition
☐ Heart Condition ☐ Thyroid
☐ Other _____

For refills: Write the Integrated HMO Pharmacy prescription number below or call 1-800-633-7928, 14 - 21 days before running out of your current prescription.

RX No. | **RX No.**
RX No. | **RX No.**
RX No. | **RX No.**

Would you like to a receive a call from a pharmacist to counsel you on your medications or to discuss your medications with you? ☐ Yes ☐ No

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. I certify that I do not have primary prescription coverage under another plan. If the prescription coverage is denied, I agree to reimburse Integrated HMO Pharmacy for the amount of benefit which is being denied under the prescription plan.

Insured's signature _____ ***Date*** _____

Method of Payment *(if applicable)*

☐ Check ☐ Money Order or Cashier's Check
☐ Mastercard ☐ Visa ☐ Discover

Credit Card Number | Expiration Date

Name as it appears on the card

Billing address of credit card _____

I understand that all co-payments and/or prescription costs for products purchased through Integrated HMO Pharmacy will be charged to the credit card provided above. 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 return of medication for any reason shall result in its immediate destruction and shall not be available for credit. I also acknowledge that the credit card information provided above is for a credit card, not a debit/check card.

Signature of cardholder _____ ***Date*** _____

Prescriptions Enclosed

Quantity of New Prescriptions _____
Quantity of Refill Prescriptions _____
Total Quantity (New + Refill) _____
Copayment Amount Enclosed $ _____