Home Delivery Refill Form

It's time to order a refill when you have a 10-14 day medication supply still on hand. To order a refill, complete this form and submit payment to CastiaRx. It's fast and easy to go online and order refills or enroll in our auto refill program – visit **CastiaRx.com/members** and click ***Order Refills***.

Patient and Prescription Information

FIRST NAME ______________________ LAST NAME ______________________

MEMBER ID ______________________ DATE OF BIRTH ______________________ PHONE NUMBER ______________________

☐ Same shipping address as previous order

SHIPPING ADDRESS ______________________

☐ Use new address for all future orders

CITY ____________ STATE ____________ ZIP ____________

Medication Name & Strength	Rx Number (found on your last invoice)	Prescriber Name

☐ I have questions regarding my medication(s) and would like a pharmacist to call me

☐ I have new allergies and/or health conditions. Please list all: ______________________

Method of Payment

☐ Credit/Debit card on file

☐ Check or money order (a rep will contact you with your total)

☐ New method of payment (complete payment section on pg 2)

Make sure the information on this form is correct

I certify that the patient information entered on this form is correct and authorize the release of any medical information required to process this claim.

SIGNATURE (required to process order) ______________________ DATE OF SIGNATURE ______________________

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

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) ____________________

Submit this form by

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

Have a new prescription that you need filled?

If it's your first time using CastiaRx Home Delivery, complete and submit our Registration form. If you're already enrolled, have your prescriber submit your prescription by:

Fax to CastiaRx at 877.649.1910. The fax must include a fax cover sheet from the prescriber's office.

ePrescribe to CastiaRx, NABP#: 2611590, NPI#: 1285737411

Mailing the original prescription to CastiaRx at 701 Emerson Road, Suite 301, Creve Coeur, MO 63141.

Have your prescriber write your prescription for a three month or 90-day supply; the prescription must display the exact quantity to be dispensed.

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

Ditch the paperwork and switch to digital! Order refills or enroll in our auto refill program online. **Visit CastiaRx.com/members**

CastiaRx™ BELIEVE IN BETTER

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