



## RUBIDOUX PHARMACY RX BY FEDEX OR MAIL

### Introduction

Welcome to the Rubidoux Pharmacy Mail Order Program. The purpose of this program is to provide you with the opportunity to receive your prescriptions in a way that is most convenient to you. In order to participate in this program, simply fill out the attached forms and send them in a self addressed envelope to the Rubidoux Pharmacy along with your prescription.

### Compliance Packaging

The Rubidoux Pharmacy utilizes the **FastPak** system to customize prescriptions and provide them in packaging that will assist you in taking the right dosage at the right times. For instance, if you have to take several prescriptions at various times of the day, the FastPak system will package the prescriptions according to your doctors recommendations and provide customized labeling. Below is an image of what your prescriptions will look like. If you would prefer to receive your prescriptions in the conventional pill bottles, please indicate this on **page 1** of your order form.



Fastpak Compliance Packaging

### Other Important Information

Please indicate to your Pharmacist whether or not your prescription is urgent. If your prescription is urgent, you may wish to utilize our free Fedex services.

For more information regarding the Rubidoux Pharmacy go to: [www.rc-hr.com/pharmacy](http://www.rc-hr.com/pharmacy) or call 1 (877) RIVCO RX (877-748-2679).



ORDER FORM

Member Information Please provide member information below.

Member ID: \_\_\_\_\_

Daytime phone: \_\_\_\_\_

Group: \_\_\_\_\_

Evening phone: \_\_\_\_\_

Name: \_\_\_\_\_

Shipping Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

\_\_\_\_\_

Street Address: \_\_\_\_\_

\_\_\_\_\_

City, ST, ZIP: \_\_\_\_\_

Please mark the box below if you do not want your prescription sent in **Compliance packaging**.

**Patient/ doctor information** Please fill out a new section for each person requesting a prescription fill. If member has more than one prescription from the same doctor, complete one section only however, submit all prescriptions in the envelope provided. If member has prescriptions from more than one doctor, complete a new section for each doctor and include all prescriptions.

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

Sex: \_\_\_\_\_

Self       Spouse       Dependent       Domestic Partner

Doctor's last name: \_\_\_\_\_

Doctor's Phone #: \_\_\_\_\_

**Payment** You can pay by cash, check, or credit card. Make checks payable to **Rubidoux Pharmacy** and write your member ID number on the front.

Number of prescriptions sent with this order:

Payment options:  Payment enclosed       Credit Card

**For credit card payments:**       Discover       MC       Visa       AMEX

Credit Card Number     

I authorize Exclusive Care to charge this

Expiration Date      card for all orders from any person in this membership.

x  
Cardholder signature

MM      YY



**ORDER FORM**

**Patient/ doctor information continued**

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Relationship to Member (check one below)

Sex: \_\_\_\_\_

- Self       Spouse       Dependent       Domestic Partner

Doctor's last name: \_\_\_\_\_

Doctor's Phone #: \_\_\_\_\_

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Relationship to Member (check one below)

Sex: \_\_\_\_\_

- Self       Spouse       Dependent       Domestic Partner

Doctor's last name: \_\_\_\_\_

Doctor's Phone #: \_\_\_\_\_

**Important reminders and other information**

**Fill out the patient/ doctor section for each person with a prescription.**

**Be sure** you have filled out the Allergy, Medication and Health Questionnaire.

**Generic Substitution:**

Ask your pharmacist whether safe, effective, and less expensive generic drugs are right for you. Or call the Rubidoux Pharmacy and ask to speak to the pharmacist.

A Pharmacist is available Monday through Friday from 8:00 a.m. to 5:00 p.m. to answer questions concerning your prescription. If you need additional information or assistance, visit us online at: [www.rc-hr.com/pharmacy](http://www.rc-hr.com/pharmacy).

**Compliance Packaging:** The Rubidoux Pharmacy utilizes compliance packaging. If your are not interested in receiving your prescriptions in this packaging, please indicate this on page 1 of your form.

Mail your prescription(s) (and refill slips), all forms (order form and Allergy, Medication & Health Questionnaire, if applicable), and your payment in a standard business envelope to the Rubidoux Pharmacy at: **5256 Mission Blvd. Rubidoux, CA 92509**



**RUBIDOUX PHARMACY RX BY FEDEX OR MAIL**

**Allergy, Medication, and Health Questionnaire**

Your answers to the following questions will help us provide your prescription drug benefit service including, for example, filling prescriptions and alerting your doctor about the possible medication problems. Please complete the questionnaire for each person in the household eligible for prescription drug benefits with Rubidoux Pharmacy mail order program.

**Please remember to print your group and member number on both pages.**

**Section A: Member Identification and Contact**

Member Number

Daytime Telephone Number

Member/ Subscriber First Name

MI

Last Name

Street Address/ Apt Number

City

State

Zip

**Section B: Drug Allergy Conditions**

For each covered member, include their first name, date of birth and gender.

For each family member check if an allergy or bad reaction happened anytime in the past. If your allergy is not listed, please print only the name of the medication allergy in the bottom section of this chart.

*Please use blue or black ink.*

**Please add last name if different from member**

First Name:	Member	Spouse	Dependent	Dependent	Dependent
Date of Birth (MM/DD/CCYY):					
Gender (fill in the circle)	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> M <input type="radio"/> F	<input type="radio"/> M <input type="radio"/> F
Penicillin/ cephalosporin Antibiotics (e.g. ampicillin, Keflex®)					
Tetracycline antibiotics					
Erythromycin, Biaxin®, Zithromax®					
Codeine (e.g. Tylenol #3®)					
Non-steroidal anti-inflammatory drugs(NSAIDs) (e.g. ibuprofen, Advil®, Motrin®)					
Aspirin (e.g. salicylates)					
Sulfa drugs					
Iodine					
If there is a drug allergy to report and not listed above, please print only the name of the drug in the space. Example: <i>Morphine</i>					

**Please continue on next page.**



**RUBIDOUX PHARMACY RX BY FEDEX OR MAIL**

**Allergy, Medication, and Health Questionnaire**

**Section C: Medical Conditions**

Please list names of each family member enrolled in the appropriate column. Then for each family member, check next to each condition if a doctor ever said **that particular family member** has any of the following conditions.

First Name:	Member	Spouse	Dependent	Dependent	Dependent
Heart Failure (weak heart)					
High blood pressure ( <b>hypertension</b> )					
Heart attach or angina					
High cholesterol ( <b>hypercholesterolemia</b> )					
Stroke					
Chronic bronchitis or emphysema ( <b>COPD</b> )					
Asthma					
Allergies, runny nose, hay fever ( <b>allergic rhinitis</b> )					
High blood sugar ( <b>diabetes</b> )					
Thyroid disease					
Peptic, stomach or duodenal ulcer					
Gastric reflux, heartburn or esophagitis ( <b>GERD</b> )					
Inflammatory bowel disease ( <b>colitis, Crohn's disease</b> )					
High pressure in the eyes ( <b>glaucoma</b> )					
Seizures					
Poor circulation in the legs (peripheral vascular disease)					
Trouble with blood not clotting properly					
Enlarged prostate (benign prostatic hyperplasia, <b>BPH</b> )					
Arthritis					
Osteoporosis					
Depression					
Migraine headaches					
Print other medical conditions not listed above in the space provided. Example - <i>Glaucoma</i>					

5256 Mission Blvd., Rubidoux, CA 92509

Phone: 1(877) RIVCO RX (877-748-2679) Fax: (951) 955-0899 Website: [www.rc-hr.com/pharmacy](http://www.rc-hr.com/pharmacy)

Email: Rubidoux\_Pharmacy@rc-hr.com

**Please return both pages of this questionnaire with your prescription or refill order form.**