



## Mail Order Enrollment Form

Please complete and mail this form with all prescriptions. Please print or type. Please list all insurance applicable.

### Subscriber Information

\_\_\_\_\_  
 Last Name                                      First Name                                      M.I.                                      Date of Birth

\_\_\_\_\_  
 Home Address                                      City                                      State                                      ZIP

\_\_\_\_\_  
 Shipping/Billing Address\*                                      City                                      State                                      ZIP

\*If Shipping and Billing Addresses are different, please provide both addresses.

\_\_\_\_\_  
 Primary Phone                                      Secondary Phone

\_\_\_\_\_  
 E-mail Address

\_\_\_\_\_  
 Group Name (Primary)                                      Group ID #                                      Member ID#

\_\_\_\_\_  
 Group Name (Secondary)                                      Group ID #                                      Member ID#

### -----BILLING INFORMATION-----

Check Enclosed:

Please Charge My:  Visa                                       Master Card  
 Discover                                       American Express

\_\_\_\_\_  
 Credit Card \* Number:

\_\_\_\_\_  
 Expiration Date: MM/DD/YYYY

\_\_\_\_\_  
 Cardholder's Name:

\_\_\_\_\_  
 Signature:

\*Credit Card Will Be Used For All Future Orders

**Acknowledgement:** I understand that when permitted by law, NoviXus will substitute an FDA approved generic equivalent drug for any brand-name medications enclosed with this order unless specified by the Plan or prohibited by me or the prescriber in writing. For all prescriptions submitted, I certify that I or my family members are eligible to receive prescriptions under this plan. I will take personal responsibility for payment of all medications that I or my family members receive.

Member Information					Drug Allergies								
					**Please enclose additional family member information, such as drug allergies, on another piece of paper								
Family Member Name	ID Number	Date of Birth	Relationship to Subscriber	Gender M / F	None	Ampicillin	Aspirin	Codeine	Erythromycin	Penicillin	Sulfa	Tetracycline's	Other** Please Specify

Check Here if you want Easy Open Caps  
*Child-proof caps are used for safety in shipping.*

**Please print UMICH number on each prescription.**

\_\_\_\_\_  
 Signature

Mail to completed and signed form to:  
 NoviXus Pharmacy Services  
 PO Box 8004  
 Novi, MI 48376-8004

**If transferring prescriptions from another pharmacy, please include the following information on a separate sheet of paper: Member Name, Date of Birth, Medication Name and Strength, Prescriber Name and Phone Number.**

Once NoviXus has received all necessary and correct information, please allow 2 weeks for prescription order delivery.

**If you have questions, please contact  
 NoviXus Patient Care Center at  
 1-877-269-1160**

## The University of Michigan's Mail Order Provider

This Mail Order Enrollment Form is only necessary for:

- First-time orders,
- Including dependents who have been added since the last order, or
- Changing current information.

### To start your Mail Order Benefit, follow these steps:

#### Step 1: *Enroll*

Complete the mail order enrollment form or enroll online through [umich.novixus.com](http://umich.novixus.com)

#### Step 2: *Fill Your Prescription*

Mail the original prescription to NoviXus with your enrollment form, or have your health care provider send the prescription directly to NoviXus. Your provider can send the prescription to NoviXus through the following options:

- Provider E-prescribes to NoviXus
- Provider Faxes: 1-877-395-4836
- Provider Calls: 1-877-269-1159
- Patient Mails Paper Prescription: NoviXus Pharmacy Services, PO Box 8004, Novi, MI 48376-8004

#### Step 3: *Complete Payment*

Make your copayment through [umich.novixus.com](http://umich.novixus.com), by phone at **1-877-269-1160**, or by mail. NoviXus accepts major credit cards and checks.

#### How to Order REFILLS:

Online: [umich.novixus.com](http://umich.novixus.com)

Phone: 1-877-269-1160 (24-hour automated phone line)

**Refill orders should be placed two weeks prior to when the medication will be needed.**

#### Shipping

Your prescription order will be shipped using U.S. Mail. Some items may be shipped by expedited courier. Refrigerated items are shipped in accordance with FDA and manufacturer's specifications. For your security, some controlled substances may require a signature at delivery.

Prescriptions cannot legally be mailed from a mail order pharmacy (or any other pharmacy operating in the United States) to locations outside of the United States, with the exception of U.S. territories, protectorates and military installations.

## Save Time and Money with U-M's Mail Order Pharmacy



**DELIVERED TO  
YOUR DOOR**

90-day supply of  
maintenance  
medications  
delivered free of  
charge



**\$280 SAVINGS**

Estimated annual  
savings for an  
average family moving  
their maintenance  
medications from retail  
to mail order



**UNDER 5 MINUTES  
TO CREATE AN ACCOUNT**

**877-269-1160**

[umich.novixus.com](http://umich.novixus.com)

If you or someone in your family takes maintenance medications, sign up for free home delivery of 90-day supplies and save.

*Any medications prescribed to be taken for three months or longer may be considered a maintenance medication. Common examples include blood pressure or cholesterol medications.*



Visit [benefits.umich.edu/mailorder](http://benefits.umich.edu/mailorder)  
to learn more