

Winston-Salem HEALTH CARE PHARMACY

Remarkable People. Remarkable Medicine.

Winston Salem Health Care Home Delivery Pharmacy

255 Charlois Blvd. Winston Salem, NC 27103

Phone: 336-718-1044 **Toll Free:** 1-888-718-9044

Fax: 336-718-1495

Email: infowshcpharmacy@novanthealth.org

INSTRUCTIONS FOR ORDERING HOME DELIVERY PRESCRIPTIONS

Welcome to the Winston-Salem Health Care Home Delivery Pharmacy. The home delivery program is perfect for patients that require medication on a recurring basis. Your medications will be delivered directly to your home, making it convenient for you. **A new form must be filled out for each patient using Winston-Salem Health Care Home Delivery Pharmacy. Please provide your signature where required to authorize.**

Step 1 – Obtain 90-day Prescription

First, you must obtain a written prescription from your doctor for up to a **90-day supply with 3 refills**. Please have your doctor verify if your particular medication qualifies for a 90-day prescription as only certain drugs are available for a 90-day supply. You may mail this prescription along with your Home Delivery Form or have your physician fax the prescription to 336-718-1495.

Step 2 – Fill out Home Delivery Form

Completely fill out the form on the back of this page and sign where appropriate. Please print clearly and fill out all required sections of the home delivery form. Failure to completely fill out the form delays the processing of your order. **Remember: use one home delivery form for each patient ordering medication(s).** Please send this form to Winston-Salem Health Care Home Delivery Pharmacy by fax at 336-718-1495 or mail to 255 Charlois Blvd., Winston-Salem, NC 27103

Step 3 – Select Payment Option

If paying by credit card, make sure to include your credit card number and expiration date. Your order will not be processed or shipped without payment in full. Standard shipping for mail order prescriptions is free. Additional costs will apply if you request expedited shipping.

Step 4 – Submit form to Winston Salem Health Care Home Delivery Pharmacy

Mail a copy of your completed form and prescription(s) to: Winston-Salem Health Care Home Delivery Pharmacy, 255 Charlois Blvd., Winston-Salem, NC 27103

Step 5 – Refills

Refills can be obtained in three ways. Visit <https://refills.novanthealth.org> and click on the "Online Refill" link and follow the simple instructions provided. This secure service is available 24 hours a day, 7 days a week. Call Winston Salem Health Care Home Delivery Pharmacy at 1-888-718-9044, or mail your refill request to Winston-Salem Health Care Home Delivery Pharmacy, 255 Charlois Blvd., Winston-Salem, NC 27103.

Medication Supply Considerations

To maximize your savings, have your doctor write a prescription for a 90-day supply with 3 refills. If you need a prescription filled before you receive your 90-day supply from the Winston-Salem Health Care Home Delivery Pharmacy, ask your doctor to write an additional 30-day prescription that you can have filled at your local pharmacy while your Winston Salem Health Care Home Delivery Pharmacy order is processed. **Please note: Prescriptions will be filled as written by your doctor. For example: if the prescription specifies a 30-day supply rather than 90-day supply, Winston-Salem Health Care Home Delivery Pharmacy can only fill the prescription for a 30-day supply.**

Winston Salem Health Care Home Delivery Pharmacy regulations prohibit patient requests to return or cancel prescription orders after the order has been shipped and received by the patient.

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Use one order form for each patient ordering medication(s). Please print clearly.

1 – Patient Information

Member ID # _____	Last Name _____	MI _____	First Name _____
Date of Birth (mm / dd / yyyy) ____ / ____ / ____	Patient Relation to Member I = Insured S = Spouse D = Dependent _____	Gender (circle one) Male Female	

2 – Shipping Address

Street _____			City _____		
State _____	Zip _____	Home Phone _____	Work Phone _____	Cell Phone _____	Email Address _____

3 – Drug Allergies

Yes / No If yes, please list (attach additional pages if necessary)

4 – Member ID Card Information

Cardholder Last Name (if different from patient) _____	MI _____	First Name _____
Member ID # _____	Group # _____	

5 – Payment Information

Credit Card: (Circle one) MasterCard Visa Credit Card # _____

Expiration Date: _____ / _____ Name on Card: _____

Signature: _____ (signature authorizes charge to my credit card)

6 – Prescription Information

Medication Name, Strength, Quantity	Doctor's Name	Doctor's Phone Number	Refill Rx Number
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

7 – Patient Authorization

By signing below, I certify that the information on this form is correct, and I authorize release of information regarding my medical and prescription drug history to Winston Salem Health Care Home Delivery Pharmacy.

Date: _____ / _____ / _____ Signature: _____

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