



Prescription Delivery Service (Mail Order)

VRx byMail provides the convenience of shipping medications directly to you, often at a lower price than your local retail pharmacy.*

Register

Before ordering a new prescription or requesting a refill, all members must register with VRx byMail. VRx provides four easy options for registering to use VRx byMail:

Online: Log into your DMBA account, click on the *Medical/Dental/Rx* tab, then in the *Options* column that appears on the left side, click on *Prescription Benefits*, click on *Request a Mail Order Prescription*.

By Mail: Complete the enclosed *Mail Order Registration Form* and send it to:

VRx byMail
P.O. Box 25428
Salt Lake City, UT 84125

By Phone: Call Member Advocates at 801-433-6233, or toll free at 855-271-4810.

By Fax: Fax the completed *Mail Order Registration Form* to: 801-433-6219.

Payment is required prior to shipping.

New Prescriptions

Electronically: This is the fastest way to order and receive your prescriptions. Ask your prescriber to send your prescription electronically to VRx byMail.

By Fax: 385-549-8898 (We can *only* accept faxed prescriptions from your provider's office.)

By Mail: Write the DMBA ID number and date of birth on the prescriptions and mail to:

VRx byMail
P.O. Box 25428
Salt Lake City, UT 84125

Prescription Refills

Online: Order refills online by logging into your DMBA account.

By Phone: Call 801-433-6233 Monday through Friday, 8 a.m.–6 p.m. Mountain Time, or toll free at 855-271-4810.

By Mail: Send the reorder form or mail original prescriptions with your DMBA ID number and date of birth to:

VRx byMail
P.O. Box 25428
Salt Lake City, UT 84125

* Actual benefits may vary based upon your specific plan design and pharmacy benefit.

Frequently Asked Questions



How do I start using VRx byMail?

Registration is required before requesting a refill or sending a new prescription to VRx byMail. We have provided four easy options for registration; online, by mail, by phone or by fax. Registration is required for each mail order participant. Please refer to the instructions on the front of this letter for additional details or call VRx byMail Member Advocates at 801-433-6233, or toll free at 855-271-4810.

Can prescriptions be transferred from another pharmacy?

VRx byMail recommends obtaining a new prescription from your prescriber. Your prescriber can send new prescriptions via fax, phone, mail, or electronic prescription (preferred). If you need help contacting your prescriber to obtain a new prescription, please contact our Member Advocates Team.

How long does it take to receive my prescriptions?

You should allow for up to 14 days from the time you request an order to the time it is delivered. Most orders will take less time but it is best to allow a few extra days to accommodate unexpected delays.

Medication refills are anticipated to process and be received more quickly than new prescription requests.

Does VRx byMail immediately fill any prescriptions sent by my provider? Am I notified?

When we receive a new prescription from your prescriber, we will reach out to you to make sure that you would like us to fill that prescription. Once we have received confirmation that you would like the prescription, we will fill and ship the medication to you.

Am I notified if there is an issue with my prescription?

Yes. If your prescription will be delayed by three or more days, you will be notified via your preferred communication method (phone, text, email). You can change your preferred communication method through your online profile or by calling VRx byMail.

If your medication is out of refills, we will contact your prescriber to obtain a new prescription.

Do I have to pay for my prescription before it will be shipped?

Yes. VRx byMail must receive payment for the medication prior to shipment. You will receive a detailed receipt with your prescription. VRx byMail accepts Visa, MasterCard, Discover, American Express, Flexible Spending Accounts (FSA), and Health Savings Accounts (HSA).

Mail Order Registration Form



Registration with VRx byMail is required for each participant before requesting a refill or sending a new prescription to be filled. Please complete the registration form below and fax or mail to VRx byMail.

You can also register by calling VRx byMail at 801-433-6233, or toll free at 855-271-4810, or online by logging into your DMBA account, click on the *Medical/Dental/Rx* tab, then in the *Options* column that appears on the left side, click on *Prescription Benefits*, click on *Request a Mail Order Prescription*.

Personal Information			
_____	_____	_____	
Last Name	First Name	Middle	
____/____/____	Gender: <input type="radio"/> Male <input type="radio"/> Female	_____	
Date of Birth		DMBA ID Number	
_____	_____	_____	_____
Primary Address	City	State	ZIP
_____	_____	_____	_____
Shipping Address (if different)	City	State	ZIP
Note: We cannot ship FedEx to P.O. boxes.			
(____) _____ - _____	_____		
Preferred Phone Number	Email Address		

Preferred Contact Method (specify number/email)
<input type="radio"/> Automated calls: (____) _____ - _____ <input type="radio"/> Text message: (____) _____ - _____
<input type="radio"/> Email: _____

Drug Allergies
<input type="radio"/> No Known <input type="radio"/> Aspirin <input type="radio"/> Acetaminophen <input type="radio"/> Cephalosporins <input type="radio"/> Codeine
<input type="radio"/> Erythromycin <input type="radio"/> NSAIDS <input type="radio"/> Penicillin <input type="radio"/> Quinolones <input type="radio"/> Sulfa
<input type="radio"/> Tetracyclines <input type="radio"/> Other _____

Health Conditions
<input type="radio"/> No Known <input type="radio"/> Asthma <input type="radio"/> Bleeding Disorder <input type="radio"/> COPD
<input type="radio"/> Diabetes <input type="radio"/> GERD/Ulcer <input type="radio"/> Heart Disease <input type="radio"/> Hypertension
<input type="radio"/> Depression <input type="radio"/> Kidney Disease <input type="radio"/> High Cholesterol <input type="radio"/> Liver Disease
<input type="radio"/> Other _____

Payment Method	
_____	____/____
Credit Card Number	Expiration Date
_____	____/____/____
Signature	Date
(By signing above I am giving permission to process my medication(s) and charge my account for my order.)	



Prescription Reorder Form

Prescription Numbers Requested (if not known, please specify drug name and dose):

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____

Feel free to give us a call with any questions regarding
your mail order prescriptions.

801-433-6233 or toll free at 855-271-4810

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