

Express Scripts Pharmacy Prescription Order Form

To order online: sign in at www.StartHomeDelivery.com and follow the prompts.

To order by mail: complete this form and ask your doctor to write your prescription for a 90-day supply or the maximum days allowed by your plan.

- Use ALL CAPITAL LETTERS in BLACK INK. Fill in the ovals as shown (●).
- Remember to mail your prescription with this completed form. Your medication will arrive within two weeks from the date we receive your first order.

NOTE: Standard shipping is FREE for online and mail orders.



PATIENT 1 (CARDHOLDER)

ID Card Number 1041

First Name MI Date of Birth (MM/DD/YYYY) / /

Last Name Gender M F

Some medications cannot be delivered to a PO Box. Provide a street address to allow delivery of your order.

Shipping Address 1

Shipping Address 2

City State

Zip Code - Check here for rush shipment. Your order, once received and filled, will be shipped overnight for \$21.

Email

Please select one as your preferred telephone number

Daytime Phone () -

Evening Phone () -

Cell Phone () -

Doctor/Prescriber Last Name Doctor/Prescriber Phone Number () -

PATIENT 2

First Name MI Date of Birth (MM/DD/YYYY) / /

Last Name Gender M F

Email

Doctor/Prescriber Last Name Doctor/Prescriber Phone Number () -

PAYMENT

All individuals included in the family will be charged to this credit card.

Apply to this order only Apply to all orders

Check Card Credit Card Check / Money Order

Amount Enclosed \$.

Card # Exp. Date (MM/YY) /

Sign here to authorize card payment

MLRFOHN JAB14553 REV 05/23/2013

Fold and tear off this piece before putting in the return envelope.

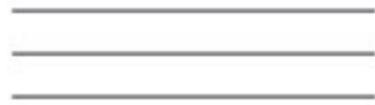
SAMPLE



EXPRESS SCRIPTS®
HOME DELIVERY SERVICE
PO BOX 747000
CINCINNATI OH 45274-7000



Postage Required
Post Office will
not deliver
without proper
postage



MLRFOHN JAB14553 REV 05/23/2013

REMINDER: This section must be removed before mailing.



1042

Patient 1 (Cardholder)		Patient 2				
Name: _____		Name: _____				
<input type="checkbox"/> I want non-child resistant caps, when available.		<input type="checkbox"/> I want non-child resistant caps, when available.				
Date of Birth (MM/DD/YYYY)		Date of Birth (MM/DD/YYYY)				
<input type="text"/> / <input type="text"/> / <input type="text"/>		<input type="text"/> / <input type="text"/> / <input type="text"/>				
DRUG ALLERGIES	List other Allergies here:	<input type="checkbox"/> No Known Allergies <input type="checkbox"/> Acetaminophen/Tylenol® <input type="checkbox"/> Amoxicillin <input type="checkbox"/> Aspirin <input type="checkbox"/> Cephalosporin (i.e., Keflex®, Cephalexin) <input type="checkbox"/> Codeine <input type="checkbox"/> Erythromycin, Biaxin®, Zithromax® <input type="checkbox"/> NSAIDs (i.e., Ibuprofen, Naproxen) <input type="checkbox"/> Oxycodone (i.e., OxyContin®, Percocet®) <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Tetracycline (i.e., Doxycycline, Minocycline)	List other Allergies here:			
	HEALTH CONDITIONS	List other Health Conditions here:	<input type="checkbox"/> No Known Health Conditions <input type="checkbox"/> Arthritis (715.9) <input type="checkbox"/> Asthma (493.9) <input type="checkbox"/> Chronic Bronchitis or Emphysema (496) <input type="checkbox"/> Depression (311) <input type="checkbox"/> Diabetes Type I (250.01) <input type="checkbox"/> Diabetes Type II (250.00) <input type="checkbox"/> Epilepsy/Seizures (345.9) <input type="checkbox"/> GERD (530.81) <input type="checkbox"/> Glaucoma (365.9) <input type="checkbox"/> High Cholesterol (272.9) <input type="checkbox"/> Hormone Replacement Therapy (627.9) <input type="checkbox"/> Hypertension (401.9) <input type="checkbox"/> Thyroid: Low (244.9)	List other Health Conditions here:		
		OTC	List other OTC that you take on a regular basis:	<input type="checkbox"/> No Over-the-Counter Medications <input type="checkbox"/> Acetaminophen/Tylenol® <input type="checkbox"/> Advil®/Aleve®/Motrin® <input type="checkbox"/> Aspirin/Excedrin®	List other OTC that you take on a regular basis:	
			DEVICES	List Medical Devices here:	<input type="checkbox"/> No Medical Devices <input type="checkbox"/> Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.	List Medical Devices here:
				OTHER	List other Prescription Medications here:	<input type="checkbox"/> No Other Prescriptions <input type="checkbox"/> Prescription Medications not filled through Express Scripts Pharmacy.

FDA approved generic medications will be dispensed when allowed by your doctor, subject to the terms outlined in your plan. I certify that all the information on this form is correct. I permit Express Scripts Inc. to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment or health care operations.

Signature Required _____

More than two family members on your plan? On a separate sheet of paper, write the family member(s) name, date of birth, allergies and health conditions along with the name and phone number of their doctor/prescriber.

Please Note: Your order may be filled at any one of our Express Scripts Pharmacies located nationwide.

SAMPLE

Moisten and fold this flap to seal return envelope.