Express Scripts New Patient Home Delivery Form

1. Ask your doctor to write your prescription quantity for a 90-day supply.
2. Use **ALL CAPITAL LETTERS** in **BLACK INK.** Fill in the ovals as shown (●).
3. To avoid delays, please include this completed form with your first order. Standard shipping is FREE and should arrive within 14 days from the date we receive your order.

Fill in this oval if you have more than two family members. Write their name, date of birth, gender, allergy and health conditions along with doctor information on a separate sheet of paper.

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Detach Here

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

PATIENT 1 (CARDHOLDER)

ID Card Number

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 X

Detach Here

MLR-WLPMSN (STL MAILER) JAB11492 REV 01/27/2010

Mail completed form to:
Express Scripts
Home Delivery Service
PO Box 66558
Saint Louis, MO 63166-6588

REMINDER: This section must be removed before mailing.

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Patient 1 (Cardholder)		Patient 2
Name: _____ I want non-child resistant caps, when available. Date of Birth (MM/DD/YYYY) __/__/____	**Date of Birth is required for patient identification.** Failure to provide complete and accurate information may prevent the pharmacy from detecting drug related problems.	Name: _____ I want non-child resistant caps, when available. Date of Birth (MM/DD/YYYY) __/__/____
DRUG ALLERGIES		
List other Allergies here:	**No Known Allergies** Acetaminophen/Tylenol® Amoxicillin Aspirin Cephalosporin (i.e., Keflex®, Cephalexin) Codeine Erythromycin, Biaxin®, Zithromax® NSAIDs (i.e., Ibuprofen, Naproxen) Oxycodone (i.e., OxyContin®, Percocet®) Penicillin Sulfa Tetracycline (i.e., Doxycycline, Minocycline)	**List other Allergies here:**
HEALTH CONDITIONS		
List other Health Conditions here:	**No Known Health Conditions** Arthritis (715.9) Asthma (493.9) Chronic Bronchitis or Emphysema (496) Depression (311) Diabetes Type I (250.01) Diabetes Type II (250.00) Epilepsy/Seizures (345.9) GERD (530.81) Glaucoma (365.9) High Cholesterol (272.9) Hormone Replacement Therapy (627.9) Hypertension (401.9) Thyroid: Low (244.9)	**List other Health Conditions here:**
OTC		
List other OTC that you take on a regular basis:	**No Over-the-Counter Medications** Acetaminophen/Tylenol® Advil®/Aleve®/Motrin® Aspirin/Excedrin®	**List other OTC that you take on a regular basis:**
DEVICES		
List Medical Devices here:	**No Medical Devices** 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:	**No Other Prescriptions** Prescription Medications not filled through Express Scripts Pharmacy.	**List other Prescription Medications here:**

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 X _____