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.

1041

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

MLRSTLF14N JAB00000 REV 10/19/2012

Detach Here

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EXPRESS SCRIPTS®
HOME DELIVERY SERVICE
PO BOX 66577
ST LOUIS MO 63166-6577

Postage Required
Post Office will not deliver without proper postage

REMINDER: This section must be removed before mailing.

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Patient 1 (Cardholder)		Date of Birth is required for patient identification.	Patient 2
Name: _____			Name: _____
I want non-child resistant caps, when available.			I want non-child resistant caps, when available.
Date of Birth (MM/DD/YYYY)			Date of Birth (MM/DD/YYYY)
DRUG ALLERGIES			
List other Allergies here:		**No Known Allergies**	List other Allergies here:
		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)	
HEALTH CONDITIONS			
List other Health Conditions here:		**No Known Health Conditions**	List other Health Conditions here:
		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)	
OTC			
List other OTC that you take on a regular basis:		**No Over-the-Counter Medications**	List other OTC that you take on a regular basis:
		Acetaminophen/Tylenol®	
		Advil®/Aleve®/Motrin®	
		Aspirin/Excedrin®	
DEVICES			
List Medical Devices here:		**No Medical Devices**	List Medical Devices here:
		Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.	
OTHER			
List other Prescription Medications here:		**No Other Prescriptions**	List other Prescription Medications here:
		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 X _____

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.

Moisten and fold this flap to seal return envelope.