



Postage Required
Post Office will not deliver without proper postage

EXPRESS SCRIPTS®
HOME DELIVERY SERVICE
PO BOX 66567
ST LOUIS MO 63166-6567



SAMPLE

PAYMENT		PATIENT 2		PATIENT 1 (CARDHOLDER)	
Sign here to authorize card payment <input checked="" type="checkbox"/>		Card # <input type="text"/>		ID Card Number <input type="text"/>	
<input type="checkbox"/> Apply to this order only <input type="checkbox"/> Check Card <input type="checkbox"/> Credit Card <input type="checkbox"/> Check / Money Order <input type="checkbox"/> Apply to all orders		Last Name <input type="text"/> First Name <input type="text"/> MI <input type="text"/> Date of Birth (MM/DD/YYYY) <input type="text"/>		Last Name <input type="text"/> First Name <input type="text"/> MI <input type="text"/> Date of Birth (MM/DD/YYYY) <input type="text"/>	
Amount Enclosed \$ <input type="text"/>		Doctor/Prescriber Last Name <input type="text"/> Doctor/Prescriber Phone Number <input type="text"/>		Doctor/Prescriber Last Name <input type="text"/> Doctor/Prescriber Phone Number <input type="text"/>	
Exp. Date (MM/YY) <input type="text"/>		Email <input type="text"/> Gender <input type="radio"/> M <input type="radio"/> F		Please select one <input type="radio"/> Daytime Phone <input type="text"/> <input type="radio"/> Evening Phone <input type="text"/> <input type="radio"/> Cell Phone <input type="text"/>	
All individuals included in the family will be charged to this credit card.		Zip Code <input type="text"/>		Shipping Address 1 <input type="text"/> Shipping Address 2 <input type="text"/>	
<input type="checkbox"/>		Check here for rush shipment. Your order, once received and filled, will be shipped overnight for \$21.		State <input type="text"/>	

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.

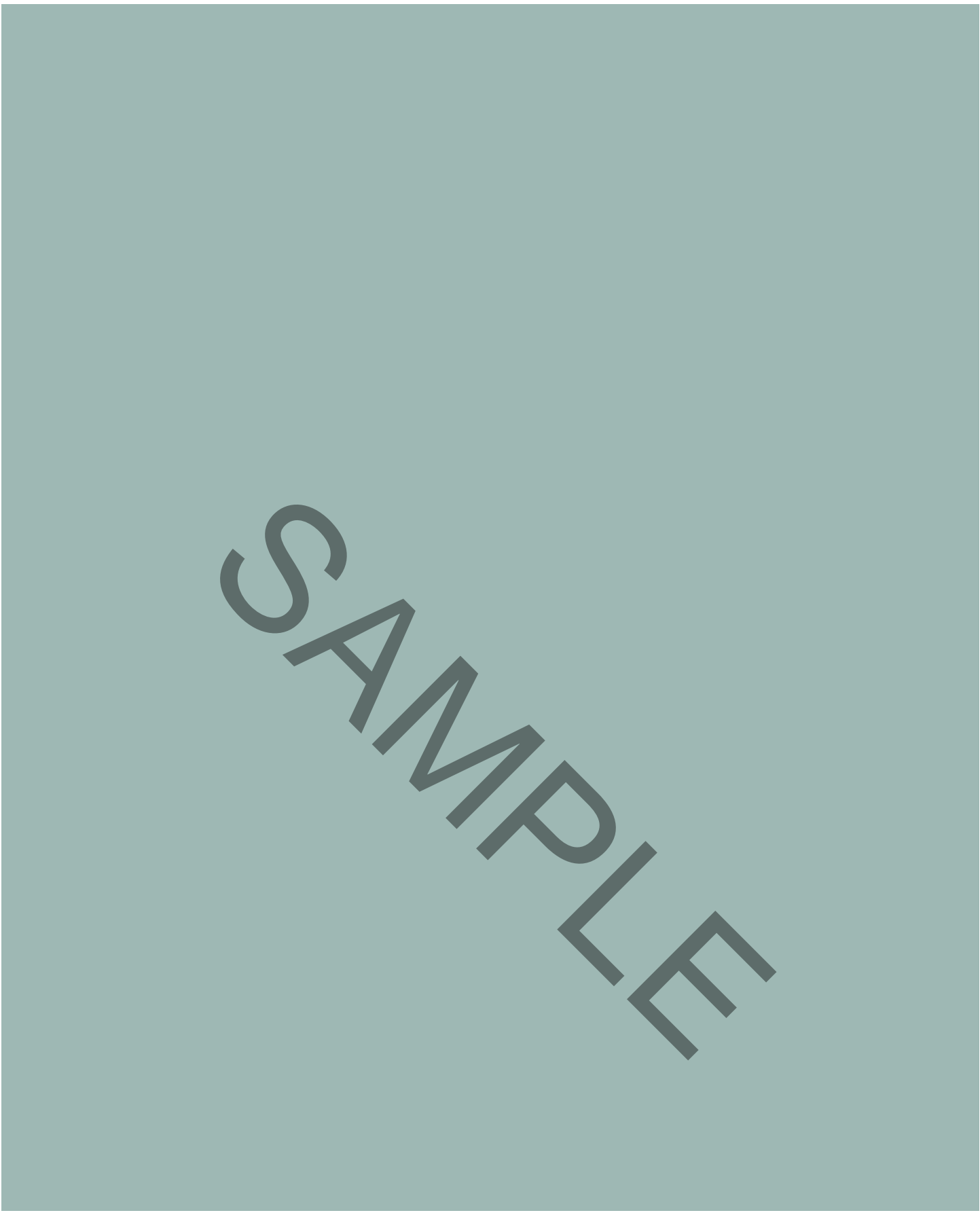
1041

Detach Here →

For all orders after 08/01/2011, use this form. Fold and tear off this piece before putting in the return envelope.

← Detach Here

Moisten and fold this flap to seal return envelope.



REMINDER: This section must be removed before mailing.

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.

Patient 1 (Cardholder)		Patient 2	
<p>Name: _____</p> <p><input type="checkbox"/> I want non-child resistant caps, when available.</p> <p>Date of Birth (MM/DD/YYYY) _____</p>		<p>Name: _____</p> <p><input type="checkbox"/> I want non-child resistant caps, when available.</p> <p>Date of Birth (MM/DD/YYYY) _____</p>	
<p>DRUG ALLERGIES</p> <p>List other Allergies here: _____</p> <p>No Known Allergies</p> <p>Acetaminophen/Tylenol® Amoxicillin Aspirin Cephalosporin (i.e., Keflex®, Cephalixin) Codeine Erythromycin, Biaxin®, Zithromax® NSAIDs (i.e., Ibuprofen, Naproxen) Oxycodone (i.e., OxyContin®, Percocet®) Penicillin Sulfas Tetracycline (i.e., Doxycycline, Minocycline)</p>		<p>HEALTH CONDITIONS</p> <p>Conditions here: _____</p> <p>No Known Health Conditions</p> <p>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)</p>	
<p>OTC</p> <p>List other OTC that you take on a regular basis: _____</p> <p>No Over-the-Counter Medications</p> <p>Acetaminophen/Tylenol® Advil®/Aleve®/Motrin® Aspirin/Excedrin®</p>		<p>DEVICES</p> <p>List Medical Devices here: _____</p> <p>Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.</p> <p>No Medical Devices</p>	
<p>OTHER</p> <p>List other Prescription Medications here: _____</p> <p>Prescription Medications not filled through Express Scripts Pharmacy.</p>		<p>OTHER</p> <p>List other Prescription Medications here: _____</p> <p>Prescription Medications not filled through Express Scripts Pharmacy.</p>	

