Express Scripts Medication Mail Order Form

To order online: visit **express-scripts.com/starthd,** select **"Register"**
To order by phone: call **1-800-892-5119** (TTY: **1-800-305-5376**)
To order using e-prescribe: ask your doctor to e-prescribe your prescription, or fax it to **1-800-837-0959**
To order by mail: complete this form using capital letters and black ink, then mail it, along with a 90-day prescription (or the maximum supply allowed) to:
Home Delivery Service
PO Box 66566, St Louis, MO 63166-9967
NOTE: *No cost standard shipping is included on all mail orders.*

1041

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

Amount Enclosed $.

- Check Card
- Credit Card
- Check / Money Order

Card #

Exp. Date (MM/YY) /

Sign here to authorize card payment X

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	Patient 1 (Cardholder)				Patient 2
	Name:		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.				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.

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