

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.



1041

PATIENT 1 (CARDHOLDER)	ID Card Number			
	First Name	MI	Date of Birth (MM/DD/YYYY)	
	Last Name			
	Gender <input type="radio"/> M <input type="radio"/> 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		<input type="checkbox"/> 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 <input type="radio"/> Daytime Phone () - <input type="radio"/> Evening Phone () - <input type="radio"/> Cell Phone () -				
Doctor/Prescriber Last Name		Doctor/Prescriber Phone Number		
PATIENT 2	First Name	MI	Date of Birth (MM/DD/YYYY)	
	Last Name			
	Gender <input type="radio"/> M <input type="radio"/> F			
	Email			
Doctor/Prescriber Last Name		Doctor/Prescriber Phone Number		
PAYMENT	All individuals included in the family will be charged to this credit card.			
	<input type="radio"/> Apply to this order only		<input type="radio"/> Apply to all orders	
	<input type="radio"/> Check Card		<input type="radio"/> Credit Card	
	<input type="radio"/> Check / Money Order		Amount Enclosed \$	
Card #				
Exp. Date (MM/YY)				
Sign here to authorize card payment <input checked="" type="checkbox"/>				



1042

Patient 1 (Cardholder)

Name: _____

I want non-child resistant caps, when available.

Date of Birth (MM/DD/YYYY)
 / /

DRUG ALLERGIES

List other Allergies here: _____

HEALTH CONDITIONS

List other Health Conditions here: _____

OTC

List other OTC that you take on a regular basis: _____

DEVICES

List Medical Devices here: _____

OTHER

List other Prescription Medications here: _____

Date of Birth is required for patient identification.

Failure to provide complete and accurate information may prevent the pharmacy from detecting drug related problems.

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)

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)

No Over-the-Counter Medications

Acetaminophen/Tylenol®
 Advil®/Aleve®/Motrin®
 Aspirin/Excedrin®

No Medical Devices

Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.

No Other Prescriptions

Prescription Medications not filled through Express Scripts Pharmacy.

Patient 2

Name: _____

I want non-child resistant caps, when available.

Date of Birth (MM/DD/YYYY)
 / /

List other Allergies here: _____

List other Health Conditions here: _____

List other OTC that you take on a regular basis: _____

List Medical Devices here: _____

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 _____

MLR-WLPFTW (STL MAILER) JAB11501 REV 01/27/2010



Postage
Required
Post Office will
not deliver
without proper
postage



EXPRESS SCRIPTS®

**HOME DELIVERY SERVICE
PO BOX 66785
SAINT LOUIS MO 63166-6785**

