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.

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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

MLRFOHN JAB14553 REV 05/23/2013

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EXPRESS SCRIPTS®
HOME DELIVERY SERVICE
PO BOX 747000
CINCINNATI OH 45274-7000

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. Failure to provide complete and accurate information may prevent the pharmacy from detecting drug related problems.		Patient 2
Name: _____ I want non-child resistant caps, when available. Date of Birth (MM/DD/YYYY) / /				Name: _____ I want non-child resistant caps, when available. 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** 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 _____

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.