Express Scripts New Patient Home Delivery Form

1. Ask your doctor to write your prescription for the maximum days supply allowed by your prescription benefit.
2. Use **ALL CAPITAL LETTERS** in **BLACK INK.** Fill in the ovals as shown (●).
3. Please send this form with the first order. Standard shipping is FREE. The order should arrive in 2 weeks.

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Tear Here

PATIENT (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.
Give a street address for delivery of your order.

Shipping Address 1

Shipping Address 2

City | State

Zip Code

○ Fill in the oval for rush delivery. Once your order is received and filled, it 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 ( ) —

QUESTIONS?

Questions about home delivery from the Express Scripts pharmacy?

Call us at **1-888-565-8361**,
24 hours a day, 7 days a week.

Hearing-impaired users call **1-800-221-6915.**

PAYMENT

Provide payment information below.

○ Apply to this order only ○ Apply to all orders

○ Bill Me Later®: Register Online or contact customer service for details. Bill Me Later® is subject to credit approval.

Amount $.

○ Check Card ○ Credit Card ○ Check / Money Order

Card # | Exp. Date (MM/YY) /

Sign here to ok payment X

Tear Here

Fold and tear before sending.

REMINDER: Remove this section before mailing to save these telephone numbers.

Questions about home delivery from the Express Scripts pharmacy? Call Express Scripts Home Delivery Pharmacy at **1-888-565-8361**, 24 hours a day, 7 days a week. Hearing-impaired users should call **1-800-221-6915.**

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It is very important that you fill in this table as shown (●). Complete this form to avoid drug-related problems.

DRUG ALLERGIES	● **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	● **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	● **No Over-the-Counter Medications**	**List other Over-the-Counter medications that you take on a regular basis:**
	● Acetaminophen/Tylenol®	
	● Advil®/Aleve®/Motrin®	
	● Aspirin/Excedrin®	
DEVICES	● **No Medical Devices**	**List Medical Devices here:**
	Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.	
OTHER	● **No Other Prescriptions**	**List other Prescription Medications here:**
	Prescription Medications filled through other pharmacies than Express Scripts.	
CAPS	● **I want non-child resistant caps, when available.**	

I understand FDA-approved generic medications will be dispensed when allowed by my doctor, subject to the terms of my plan. I certify that all the information on this form is correct. I permit Express Scripts Inc. to release the 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 _____

Wet and fold this flap to seal envelope.

Postage Required
Post Office wil not deliver without proper postage

EXPRESS SCRIPTS®

HOME DELI VERY SERVI CE
PO BOX 66785
SAI NT LOUI S MO 63166-6785