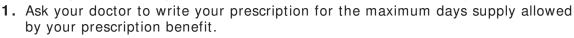
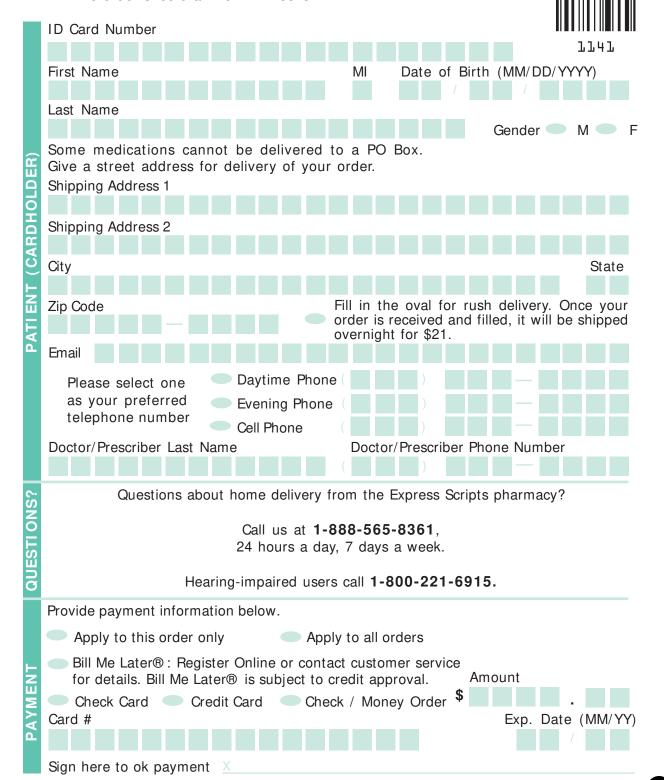
Express Scripts New Patient Home Delivery Form





- 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.



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

7 days a week.

24 hours a day,

1. 1. 4 2

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

DRUG ALLERGI ES	Acetaminophen/Tylenol® Amoxicillin Aspirin Combolographic (i.e., Kofley®, Combologia)		
m —	Aspirin		
LERGIE			
HER	Combalage (i.e. Kaflay® Combalayin)		
	Cephalosporin (i.e., Keflex®, Cephalexin)		
	Codeine		
4	Erythromycin, Biaxin®, Zithromax®		
	NSAIDs (i.e., Ibuprofen, Naproxen)		
E	Oxycodone (i.e., OxyContin®, Percocet®)		
	Penicillin		
	Sulfa		
	Tetracycline (i.e., Doxycycline, Minocycline)		
	No Known Health Conditions	List other Health Conditions here:	
	Arthritis (715.9)		
	Asthma (493.9)		
S	Chronic Bronchitis or Emphysema (496)		
2	Depression (311)		
	Diabetes Type I (250.01)		
	Diabetes Type II (250.00)		
8	Epilepsy/Seizures (345.9)		
	GERD (530.81)		
HEALTH CONDITIONS	Glaucoma (365.9)		
	High Cholesterol (272.9)		
	Hormone Replacement Therapy (627.9)		
	Hypertension (401.9)		
	Thyroid: Low (244.9)		
	No Over-the-Counter Medications	List other Over-the-Counter medica-	
ပ္	Acetaminophen/Tylenol®	tions that you take on a regular basis	
of of of	Advil®/Aleve®/Motrin®		
	Aspirin/Excedrin®		
_	No Medical Devices	List Medical Devices here:	
DEVICES	Medical Devices (i.e., Glucose Testing	Elot modical Bovicos noisi	
<u> </u>	Device, Insulin Pump, Nebulizer) and		
	specify brand name and model.		
	No Other Prescriptions	List other Prescription Medications	
#	Prescription Medications filled through other	here:	
ОТНЕВ	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

MLR-WLPMEDICARE (MAILER) 09/07/2010

Wet and fold this flap to seal envelope.

EXPRESS SCRIPTS HOME DELI VERY SERVI CE SAI NT LOUI S MO 63166-6785 [m					
Posisage Required Required Post Office will not deliver without proper postage					