

## 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

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 \_\_\_\_\_

\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Last Name \_\_\_\_\_ Gender  M  F

\_\_\_\_\_

Email \_\_\_\_\_

Doctor/Prescriber Last Name \_\_\_\_\_ Doctor/Prescriber Phone Number \_\_\_\_\_

\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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



1042

### Patient 1 (Cardholder)

Name: \_\_\_\_\_

I want non-child resistant caps, when available.

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

#### 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.

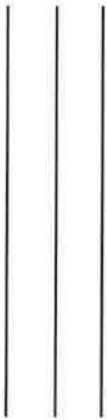
Date of Birth (MM/DD/YYYY)  
\_\_\_\_/\_\_\_\_/\_\_\_\_

|              |                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                         |
|--------------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| <b>OTHER</b> | <b>DRUG ALLERGIES</b>    | <b>List other Allergies here:</b><br><input type="checkbox"/> <b>No Known Allergies</b><br>Acetaminophen/Tylenol®<br>Amoxicillin<br>Aspirin<br>Cephalosporin (i.e., Keflex®, Cephalexin)<br>Codeine<br>Erythromycin, Biaxin®, Zithromax®<br>NSAIDs (i.e., Ibuprofen, Naproxen)<br>Oxycodone (i.e., OxyContin®, Percocet®)<br>Penicillin<br>Sulfa<br>Tetracycline (i.e., Doxycycline, Minocycline)                                                         | <b>List other Allergies here:</b>                       |
|              | <b>HEALTH CONDITIONS</b> | <b>List other Health Conditions here:</b><br><input type="checkbox"/> <b>No Known Health Conditions</b><br>Arthritis (715.9)<br>Asthma (493.9)<br>Chronic Bronchitis or Emphysema (496)<br>Depression (311)<br>Diabetes Type I (250.01)<br>Diabetes Type II (250.00)<br>Epilepsy/Seizures (345.9)<br>GERD (530.81)<br>Glaucoma (365.9)<br>High Cholesterol (272.9)<br>Hormone Replacement Therapy (627.9)<br>Hypertension (401.9)<br>Thyroid: Low (244.9) | <b>List other Health Conditions here:</b>               |
|              | <b>OTC</b>               | <b>List other OTC that you take on a regular basis:</b><br><input type="checkbox"/> <b>No Over-the-Counter Medications</b><br>Acetaminophen/Tylenol®<br>Advil®/Aleve®/Motrin®<br>Aspirin/Excedrin®                                                                                                                                                                                                                                                        | <b>List other OTC that you take on a regular basis:</b> |
|              | <b>DEVICES</b>           | <b>List Medical Devices here:</b><br><input type="checkbox"/> <b>No Medical Devices</b><br>Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.                                                                                                                                                                                                                                                      | <b>List Medical Devices here:</b>                       |
|              | <b>OTHER</b>             | <b>List other Prescription Medications here:</b><br><input type="checkbox"/> <b>No Other Prescriptions</b><br>Prescription Medications not filled through Express Scripts Pharmacy.                                                                                                                                                                                                                                                                       | <b>List other Prescription Medications here:</b>        |

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  \_\_\_\_\_

MLRBC-OH (STL MAILER) JAB11532 REV 01/27/2010



**WL5**



Postage  
Required  
Post Office will  
not deliver  
without proper  
postage



**EXPRESS SCRIPTS®**

**HOME DELIVERY SERVICE  
PO BOX 66772  
SAINT LOUIS MO 63166-6772**

