Express Scripts Pharmacy Prescription Order Form

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

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.

○ Check here for rush shipment. Your order, once received and filled, will be shipped overnight for $21.

○ 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 X

MLR-HMRK 1059769 REV 02/08/2016

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 122 LAS VEGAS, NV

POSTAGE WILL BE PAID BY ADDRESSEE

EXPRESS SCRIPTS®
HOME DELIVERY SERVICE
PO BOX 6500
CINCINNATI OH 45273-8152

MLR-HMRK 1059769 REV 02/08/2016

REMINDER: This section must be removed before mailing.

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Patient 1 (Cardholder)		Date of Birth is required for patient identification.	Patient 2
Name: _____			Name: _____
I want non-child resistant caps, when available.			I want non-child resistant caps, when available.
Date of Birth (MM/DD/YYYY)			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	
		Asthma	
		Chronic Bronchitis or Emphysema	
		Depression	
		Diabetes Type I	
		Diabetes Type II	
		Epilepsy/Seizures	
		GERD	
		Glaucoma	
		High Cholesterol	
		Hormone Replacement Therapy	
		Hypertension	
		Thyroid: Low	
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**	List Medical Devices here:
		Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.	
OTHER			
List other Prescription Medications here:		**No Other Prescriptions**	List other Prescription Medications here:
		Prescription Medications not filled through Express Scripts Pharmacy.	

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.