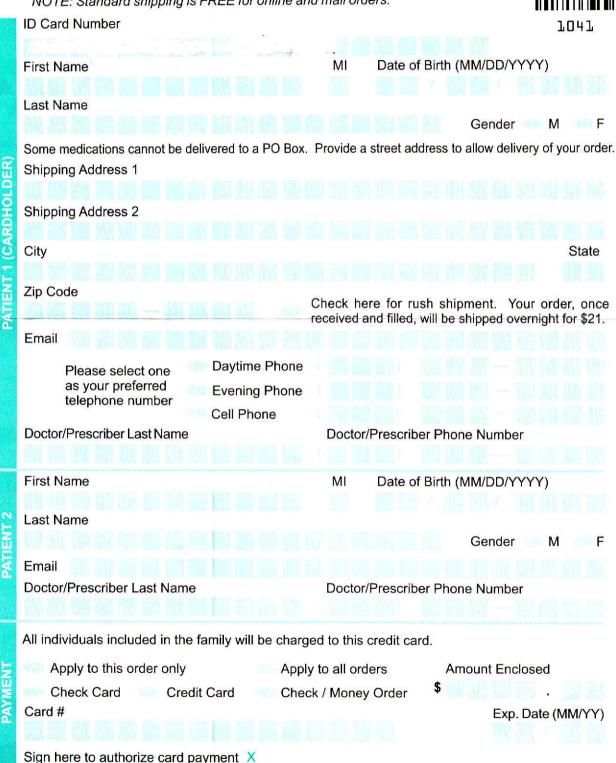
Express Scripts Pharmacy Prescription Order Form

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.







1042

Patient 2

Name:

I want non-child resistant caps, when available.

Patient 1 (Cardholder)

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.

I want non-child resistant caps, when available.

Date of Birth (MM/DD/YYYY)

Name:

		Totalog problems.		
	List other Allergies here:	No Known Allergies	List other Allergies here:	
Ø		Acetaminophen/Tylenol®		
H		Amoxicillin		
밎		Aspirin		
T	4	Cephalosporin (i.e., Keflex®, Cephalexin)		
		Codeine		
3	4	Erythromycin, Biaxin®, Zithromax®		
O	4	NSAIDs (i.e., Ibuprofen, Naproxen)		
Ð	C)	Oxycodone (i.e., OxyContin®, Percocet®)		
监		Penicillin		
H	<u> </u>	Sulfa		
		Tetracycline (i.e., Doxycycline, Minocycline)		
	List other Health Conditions here:	No Known Health Conditions	List other Health Conditions here:	
m		Arthritis		
14		Asthma		
0	9	Chronic Bronchitis or Emphysema		
E		Depression		
	4	Diabetes Type I		
Ä		Diabetes Type II	Name of the second	
ŏ		Epilepsy/Seizures		
25 to		GERD		
	40	Glaucoma		
		High Cholesterol		
쁘		Hormone Replacement Therapy		
		Hypertension		
		Thyroid: Low		
	List other OTC that you take	No Over-the-Counter Medications	List other OTC that you take	
	on a regular basis:	Acetaminophen/Tylenol®	on a regular basis:	
0		Advil®/Aleve®/Motrin®		
		Aspirin/Excedrin®		
9	List Medical Devices here:	No Medical Devices	List Medical Devices here:	
DEVICE		Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.		
	List other Prescription Medica-	No Other Prescriptions	List other Prescription Medications here:	
量	tions 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.

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Postage Required Post Office will not deliver without proper postage

PO BOX 66567 ST LOUIS MO 63166-6567

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