



Postage Required  
Post Office will not deliver without proper postage

**EXPRESS SCRIPTS®**  
HOME DELIVERY SERVICE  
PO BOX 66567  
ST LOUIS MO 63166-6567



SAMPLE

**PAYMENT**

Sign here to authorize card payment  X

Card #

Exp. Date (MM/YY)  /

Apply to this order only     Apply to all orders

Check Card     Credit Card     Check / Money Order

Amount Enclosed \$

All individuals included in the family will be charged to this credit card.

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**PATIENT 2**

Doctor/Prescriber Last Name

Doctor/Prescriber Phone Number

Email

Last Name

Gender  M  F

First Name

MI

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

Doctor/Prescriber Last Name

Doctor/Prescriber Phone Number

Please select one  Daytime Phone  Evening Phone  Cell Phone

Email

Zip Code

City

State

Shipping Address 2

Shipping Address 1

Some medications cannot be delivered to a PO Box. Provide a street address to allow delivery of your order.

Last Name

Gender  M  F

First Name

MI

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

ID Card Number

**Express Scripts Pharmacy Prescription Order Form**

**To order online:** sign in at [www.StartHomeDelivery.com](http://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.

1041

Detach Here

For all orders after 08/01/2011, use this form. Fold and tear off this piece before putting in the return envelope.

Detach Here

Moisten and fold this flap to seal return envelope.



REMINDER: This section must be removed before mailing.

Patient 1 (Cardholder)		Patient 2	
<p>Name: _____</p> <p><input type="checkbox"/> I want non-child resistant caps, when available.</p> <p>Date of Birth (MM/DD/YYYY) _____</p>		<p>Name: _____</p> <p><input type="checkbox"/> I want non-child resistant caps, when available.</p> <p>Date of Birth (MM/DD/YYYY) _____</p>	
<p><b>DRUG ALLERGIES</b></p> <p>List other Allergies here: _____</p> <p><b>No Known Allergies</b></p> <p>Acetaminophen/Tylenol® Amoxicillin Aspirin Cephalosporin (i.e., Keflex®, Cephalixin) Codeine Erythromycin, Biaxin®, Zithromax® NSAIDs (i.e., Ibuprofen, Naproxen) Oxycodone (i.e., OxyContin®, Percocet®) Penicillin Sulfas Tetracycline (i.e., Doxycycline, Minocycline)</p>		<p><b>HEALTH CONDITIONS</b></p> <p>Conditions here: _____</p> <p><b>No Known Health Conditions</b></p> <p>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)</p>	
<p><b>OTC</b></p> <p>List other OTC that you take on a regular basis: _____</p> <p><b>No Over-the-Counter Medications</b></p> <p>Acetaminophen/Tylenol® Advil®/Aleve®/Motrin® Aspirin/Excedrin®</p>		<p><b>DEVICES</b></p> <p>List Medical Devices here: _____</p> <p>Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.</p> <p><b>No Medical Devices</b></p>	
<p><b>OTHER</b></p> <p>List other Prescription Medications here: _____</p> <p>Prescription Medications not filled through Express Scripts Pharmacy.</p>		<p><b>OTHER</b></p> <p>List other Prescription Medications here: _____</p> <p>Prescription Medications not filled through Express Scripts Pharmacy.</p>	

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.

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.

