

REMINDER: This section must be removed before mailing.



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.

List other Allergies here:

DRUG ALLERGIES

No Known Allergies

Acetaminophen/Tylenol®

Amoxicillin

Aspirin

Codeine

Cephalosporin (i.e., Keflex®, Cephalexin)

Erythromycin, Biaxin®, Zithromax®

NSAIDs (i.e., Ibuprofen, Naproxen)

Oxycodone (i.e., OxyContin®, Percocet®)

Penicillin

Sulfa

Tetracycline (i.e., Doxycycline, Minocycline)

List other Health Conditions here:

HEALTH CONDITIONS

No Known Health Conditions

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)

List other OTC that you take on a regular basis:

OTC

No Over-the-Counter Medications

Acetaminophen/Tylenol®

Advil®/Aleve®/Motrin®

Aspirin/Excedrin®

List Medical Devices here:

DEVICES

No Medical Devices

Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.

List other Prescription Medications here:

OTHER

No Other Prescriptions

Prescription Medications not filled through Express Scripts Pharmacy.

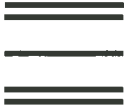
FDA approved generic medications will be dispensed when allowed by your doctor, subject to the terms outlined in your plan. I certify that all the information on this form is correct. I permit Express Scripts Inc. to release all information on this form concerning prescription orders to my plan sponsor, 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.

MLRSTLTIN JAB13077 REV 10/03/2011



Postage
Required
Post Office will
not deliver
without proper
postage



EXPRESS SCRIPTS®

HOME DELIVERY SERVICE

PO BOX 66566

ST LOUIS MO 63166-6566

will arrive within two weeks from the date we receive your first order.

NOTE: Standard shipping is FREE for online and mail orders.

ID Card Number



1041

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 X

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

Detach Here