1042

Patient 1 (Cardholder)		Patient 2
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.	Name: I want non-child resistant caps, when available. Date of Birth (MM/DD/YYYY)
DRUG ALLERGIES List other Allergies here:	**No Known Allergies** 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)	List other Allergies here:
HEALTH CONDITIONS List other Health Conditions here:	**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 Health Conditions here:
OTC List other OTC that you take on a regular basis:	**No Over-the-Counter Medications** Acetaminophen/Tylenol® Advil®/Aleve®/Motrin® Aspirin/Excedrin®	List other OTC that you take on a regular basis:
DEVICES List Medical Devices here:	**No Medical Devices** Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.	List Medical Devices here:
OTHER List other Prescription Medications here:	**No Other Prescriptions** Prescription Medications not filled through Express Scripts Pharmacy.	List other Prescription Medications here:

REMINDER: This section must be removed before mailing.

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

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.

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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

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

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.

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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Detach Here

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