Express Scripts New Patient Home Delivery Form

1. Ask your doctor to write your prescription quantity for a 90-day supply.
2. Use **ALL CAPITAL LETTERS** in **BLACK INK.** Fill in the ovals as shown (●).
3. To avoid delays, please include this completed form with your first order. Standard shipping is FREE and should arrive within 14 days from the date we receive your order.

Fill in this oval if you have more than two family members. Write their name, date of birth, gender, allergy and health conditions along with doctor information on a separate sheet of paper.

1041

PATIENT 1 (CARDHOLDER)

Prescription Card ID 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

MLR- __ __ __ (MAILER) REV 08/26/2008

Detach Here

Fold and tear off this piece before putting in the return envelope.

Detach Here

MLRBENP

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 454 BENSALEM, PA
POSTAGE WILL BE PAID BY ADDRESSEE

EXPRESS SCRIPTS®

Home Delivery Service
PO Box 1086
Bensalem, PA 19020-9380

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

Please note that all prescriptions requiring a formulary exception will not be processed without prior approval. To prevent any delays, make sure that an approved formulary exception (if applicable) is on file before you place your order.

Thank you for using our Mail Service Prescription Drug Program.

REMINDER: This section must be removed before mailing.

1042

Patient 1 (Cardholder)		Patient 2
Name: _____	It is very important that you fill in the table below as shown (●).	Name: _____
○ I want non-child resistant caps for all future orders.	Failure to provide complete and accurate information may prevent the pharmacy from detecting drug related problems.	○ I want non-child resistant caps for all future orders.
Date of Birth (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐		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:**

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 _____

PENNSYLVANIA LAW PERMITS PHARMACISTS TO SUBSTITUTE A LESS EXPENSIVE GENERICALLY EQUIVALENT DRUG FOR A BRAND NAME DRUG UNLESS YOU OR YOUR PHYSICIAN DIRECT OTHERWISE.

○ I DO NOT WANT A LESS EXPENSIVE BRAND OR GENERIC DRUG PRODUCT. I UNDERSTAND THAT BY SELECTING THIS STATEMENT, I MAY INCUR ADDITIONAL COSTS ACCORDING TO THE GUIDELINES OF MY PRESCRIPTION PLAN. WRITE 'BRAND ONLY' ON THE BACK OF ANY PRESCRIPTION YOU WANT TO RECEIVE AS A BRAND MEDICATION.

MLR- __ __ __ (MAILER) REV 08/26/2008

Did You Remember To...

- Complete all applicable information
- Include your ID number on the mail order form
- Enclose original prescription, mail order form, and appropriate copayment
- Make check or money order payable to Express Scripts,® or include credit card information