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.

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Home Delivery Service **Box 1086** 19020-9380

EXPRESS SCRIPTS

POSTAGE WILL BE PAID ВΥ ADDRESSEE

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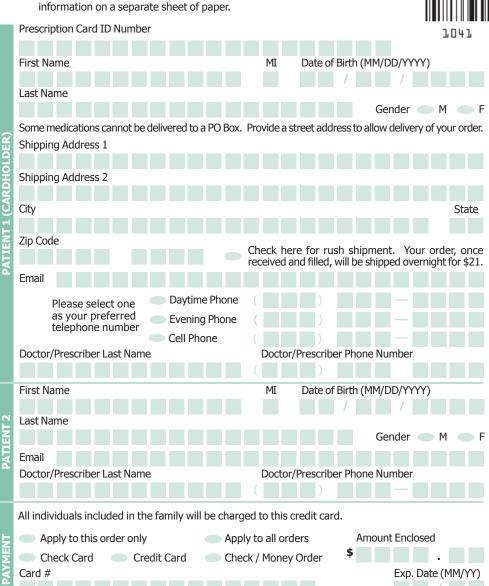
NO POSTAGE NECESSARY IF MAILED IN THE

STATE

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.



Sign here to authorize card payment

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

tear and Fold

Detach |

this piece before putting in the return envelope off





Patient 1 (Cardholder)		3042	- · · · -
		7040	Patient 2
	I want non-child resistant caps for all future orders. Date of Birth (MM/DD/YYYY) List other Allergies here:	It is very important that you fill in the table below as shown (). Failure to provide complete and accurate information may prevent the pharmacy from detecting drug related problems. 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®) Penicilin Sulfa	Name: I want non-child resistant caps for all future orders. Date of Birth (MM/DD/YYYY) List other Allergies here:
HEALTH CONDITIONS	List other Health Conditions here:	Tetracycline (i.e., Doxycycline, Minocycline) No Known Health Conditions Arthritis (715.9) Asthma (493.9) Chronic Bronchitis or Emphysema (496) Depression (311) Diabetes Type II (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:
9 <u>7</u> 2	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.

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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.

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id You Remember To...

- Include your ID number on the mail order form
- Enclose original prescription, mail order form, and appropr
- Make check or money order payable to Express