Express Scripts Pharmacy Prescription Order Form

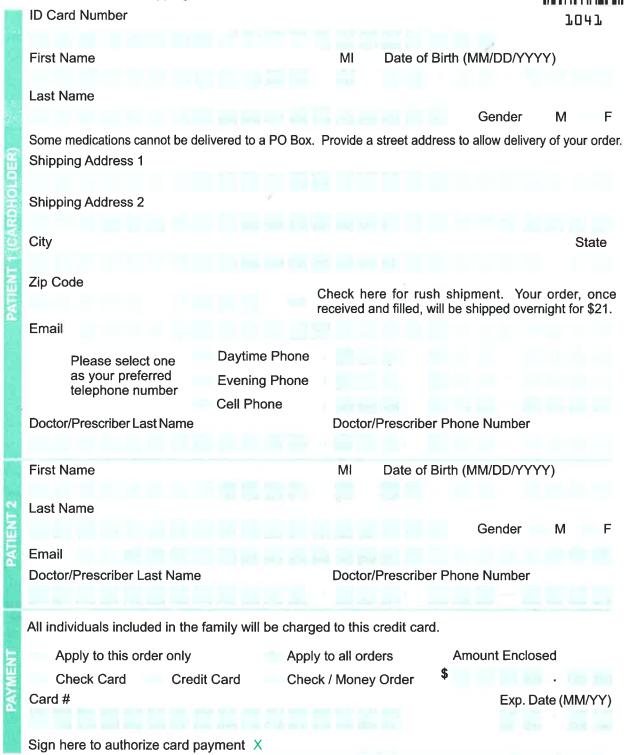
To order online: sign in at www.StartHomeDelivery.com and follow the prompts.

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.





Patient 1 (Cardholder)	1042	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 First 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 here:	No Known Health Conditions Arthritis Asthma Chronic Bronchitis or Emphysema Depression Diabetes Type I Diabetes Type II Epilepsy/Seizures GERD Glaucoma High Cholesterol Hormone Replacement Therapy Hypertension Thyroid: Low	List other Health Conditions here:
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:
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:
List other Prescription Medications here:	No Other Prescriptions Prescription Medications not filled through Express Scripts Pharmacy.	List other Prescription Medica- tions 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

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.

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES





POSTAGE WILL BE PAID BY ADDRESSEE



ST LOUIS MO 63166-9968

PO BOX 66567

