Express Scripts New Patient Home Delivery Form

1. Have your doctor write your prescription for the maximum day supply allowed by your benefit.
2. Use **ALL CAPITAL LETTERS** in **BLACK INK.** Fill in the ovals as shown (⬬).
3. Please send this form with the first order. Standard shipping is FREE. The order should arrive in 2 weeks.

○ 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.

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 ____ — ____　　○ Fill in the oval for rush delivery. Once your order is received and filled, it 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 ____________________

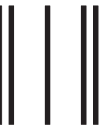
MLP-WLPMSN (WLPMAILER) REV 10/05/2010

Detach Here

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

Detach Here

MLP-WLPMSN (WLPMAILER) REV 10/05/2010



Postage Required
Post Office will not deliver without proper postage

HOME DELIVERY SERVICE
PO BOX 66558
SAINT LOUIS MO 63166-6558

REMINDER: This section must be removed before mailing.

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:**

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 ____________________

MLP-WLPMSN (WLPMAILER) REV 10/05/2010

Moisten and fold this flap to seal return envelope.