1042

Patient 1 (Cardholder)		Patient 2
Name: _____ ○ I want non-child resistant caps for all future prescriptions. Date of Birth (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐	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.	Name: _____ ○ I want non-child resistant caps for all future prescriptions. Date of Birth (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐
DRUG ALLERGIES		
List other Allergies here:	○ **No Known Allergies**	○ **List other Allergies here:**
	○ 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)	○
HEALTH CONDITIONS		
List other Health Conditions here:	○ **No Known Health Conditions**	○ **List other Health Conditions here:**
	○ 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)	○
OTC		
List other OTC that you take on a regular basis:	○ **No Over-the-Counter Medications**	○ **List other OTC that you take on a regular basis:**
	○ Acetaminophen/Tylenol®	○
	○ Advil®/Aleve®/Motrin®	○
	○ Aspirin/Excedrin®	○
DEVICES		
List Medical Devices here:	○ **No Medical Devices** List 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.

Express Scripts New Patient Home Delivery Form

1. Ask your doctor to write your prescription quantity for a 90-day supply.
2. Fill out in **ALL CAPITAL LETTERS** using **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 the 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.

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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 expedited shipping. Your order once received and filled, will be shipped overnight for $18

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 orders will be charged to the card you provide. You will be charged for all orders associated with your ID Number. Do not send cash.

○ 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

Mail to: Express Scripts Home Delivery Service, PO Box 66773, Saint Louis, MO 63166-6773