

Please complete  
All 5 SECTIONS and mail to:



**EXPRESS SCRIPTS**  
Charting the Future of Pharmacy

**MAIL PHARMACY SERVICE**  
PO BOX 66773  
SAINT LOUIS MO 63166-6773

PLEASE PRINT

**Section 1** You only need to complete this section for a covered family member the first time the person orders medication, unless any information changes. In the Comments area at right, list all medications being taken by each family member ordering medication so we can review for potential interactions. Provide additional information on a separate sheet if necessary. If anyone goes by a nickname, please write the name in the appropriate space below.

		Allergies: Please mark an "X" in the appropriate box for any allergies you or others listed on the form may have.											Comments				
		Acetaminophen (Tylenol)	Alcohol	Ampicillin	Aspirin	Penicillins and Derivatives (Keflex, Dyricef, etc.)	Cocaine	Erythromycin	Local anesthetics	Morphine and Derivatives	Penicillin	Phenytoin (Dilantin, Dilacor, etc.)	Sulfas	Sulfonamide Derivatives (Glaxolam, Ganadol, etc.)	Tetracyclines	List below any other allergies and all medications, including over-the-counter medications, each person is currently taking. Also list any illnesses or medical conditions (i.e., asthma, blood pressure). Use a separate sheet if necessary.	
Member's I.D. Number																	
If anyone has other insurance coverage, please enter name of insurance company and check box below.																	
Insurance company																	
<b>Name</b> Last First M.I. Nickname Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> No known allergies <input type="checkbox"/> Other Ins. Coverage Physician Birth Date <input type="checkbox"/> Smoker <input type="checkbox"/> Pregnant <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Drink Alcohol																	
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**Section 2** **To order:** Enclose your original written prescription(s). If you are already taking a medication, call your doctor's office and request a new prescription for the maximum days supply allowed by your health plan. **IMPORTANT: TO AVOID DELAY - PLEASE ENCLOSE CHECK, MONEY ORDER OR CREDIT CARD NUMBER FOR PROCESSING.**

**Section 3** Complete this section indicating how you wish to pay for your medication. **Please do not send cash.**

Check or money order enclosed AMOUNT ENCLOSED \$ \_\_\_\_\_ CHECK NO. \_\_\_\_\_  
 Charge to my credit card Cardholder Name \_\_\_\_\_ Account Number \_\_\_\_\_  
 Charge this and all future orders to this credit card  
 Cardholder Signature \_\_\_\_\_ Expiration Date \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Master Card  VISA  DISCOVER  American Express  Cards

**Section 4** **Tell us where to ship your order**

Check here for address change Date \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
 Name \_\_\_\_\_ Member I.D. Number \_\_\_\_\_ Daytime Phone ( ) \_\_\_\_\_  
 Last First M.I.  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Street P.O. Box Apt. No.  
 Doctor's Phone ( ) \_\_\_\_\_ Doctor's Name Dr. \_\_\_\_\_ Group/Employer Name \_\_\_\_\_

**Section 5**  
**Special Handling Required:** \_\_\_\_\_

e-mail (optional): \_\_\_\_\_

I certify that all information on this form is correct. I permit Express Scripts to release all information to plan sponsor, administrator or underwriter.

Signature Required I request this and all future orders be shipped "signature required". I understand there will be an extra charge for this service.

**EXPRESS SCRIPTS** www.express-scripts.com

Signature Required If you wish to resume receiving child-resistant containers, please check box.

**Non-Child-Resistant Containers**  
Please sign below if you want prescriptions for you or your eligible dependents dispensed in non-child-resistant containers.

## BENEFITS

- Standard postage paid
- Convenient home delivery within 14 days
- Free drug interaction screening
- Pharmacist available 24 hours
- 24 hour touch-tone service available for refills or to check status on refills
- MC, VISA, DISCOVER and American Express accepted.

## Questions & Answers

### 1. WHEN DO I USE MAIL SERVICE?

Mail service should be used for ordering medications you will take for more than 30 days.

### 2. WHAT CAN I DO TO EXPEDITE PROCESSING OF THE PRESCRIPTION(S)?

**Is the name clearly written on the prescription?**

If not, please print the patient's full name, address and phone number on back of the prescription.

**Is the doctor's signature legible and is the office phone number on the prescription?**

If not, please circle the doctor's name on prescription blank or print the name clearly on the back of the prescription, along with a phone number.

**Are the directions and quantities on the prescriptions clear?**

If the doctor writes "As directed," this could delay your order.

**Does the patient's condition require long term therapy?**

If so, ask the doctor to write the prescription for the maximum quantity allowed by the prescription plan. Make sure the doctor allows for generic substitution as this maximizes your healthcare dollar!

**Have you completely filled out the attached mailer envelope including evening phone number, if different from your daytime phone number?**

This helps us if it is necessary to contact you.

### 3. WHY ARE THE PATIENT'S ALLERGIES AND HEALTH CONDITION IMPORTANT?

Registered pharmacists review the patient's record prior to filling the prescriptions to identify potential adverse reactions and interaction problems.

### 4. HOW DO I TRANSFER MY PRESCRIPTIONS TO EXPRESS SCRIPTS?

Call the doctor's office and request a new prescription for the maximum days supply allowed by the prescription plan and mail it to:

**Express Scripts**  
**Attn: Mail Pharmacy, Box 66773**  
**St. Louis, MO 63166-6773**

### OTHER QUESTIONS:

Please Call  
Customer Service  
at the number located  
on your card

