

Complete the member, shipping and payment information sections and ask your physician to complete the prescription information section. Your physician can fax the completed order form, along with a cover sheet, to Express Scripts at 800-905-9815.

Faxed orders cannot be accepted when faxed by the patient. Prescriptions for schedule II controlled substances must be submitted by mail.

SECTION 1: MEMBER INFORMATION

Provide policy or cardholder information as found on the health plan or benefit card. Please do not write on the back of form.

Name of Your Health Plan Identification Number

Policy or cardholder last name First name Initial Date of birth (MM/DD/YYYY)

Patient last name First name Initial Patient date of birth (MM/DD/YYYY) Patient gender M F

Drug allergies (check all that apply): Penicillin Aspirin Codeine Sulfa
 Other (list all, including over-the-counter medications)

Medical history (check all that apply): Diabetes Glaucoma High blood pressure Arthritis Thyroid Heart condition
 Asthma Other (list all)

SECTION 2: SHIPPING INFORMATION

Orders ship within seven days of receipt of valid order. Controlled and refrigerated medications cannot ship to a PO box. Schedule II controlled substances require signature on delivery.

New address Y N Permanent address Y N Street address Apartment/suite

City State ZIP code Daytime phone # (including area code)

E-mail address Evening phone # (including area code)

SECTION 3: PAYMENT INFORMATION

Payment is required before an order will ship. Do not send cash. Make checks and money orders payable to Express Scripts. There is a \$25 fee for returned checks. Credit cards are charged for the entire order and used for future orders unless a new payment method is specified. Overnight shipping does not expedite prescription processing time.

Payment method: Check Visa MasterCard American Express Discover Overnight Shipping (add \$20)

Account number Expiration date Signature/date

Amount enclosed: Coupon Code:

Please place prescription(s) on file for later. Do not dispense at this time.

SECTION 4: PRESCRIPTION INFORMATION - FOR PHYSICIAN USE ONLY

Federally approved, generic-equivalent medications will be dispensed for brand name medications unless otherwise directed by the patient, physician, or health plan.

Patient Name:	Date of Birth:	Today's Date:
Rx SIG: (Avoid "As Directed" or specify quantity) Quantity: (100 day supply OR) Refill for One (1) Year or _____ Times NR PRESCRIPTION WILL BE REFILLED FOR ONE YEAR UNLESS OTHERWISE INDICATED.	Rx SIG: (Avoid "As Directed" or specify quantity) Quantity: (100 day supply OR) Refill for One (1) Year or _____ Times NR PRESCRIPTION WILL BE REFILLED FOR ONE YEAR UNLESS OTHERWISE INDICATED.	
Physician Signature:	NPI Number:	
Physician Name/Address (Required by state pharmacy law):	Physician Phone:	