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.

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

Zip Code

Check here for rush shipment. Your order, once received and filled, 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

First Name MI Date of Birth (MM/DD/YYYY)

Last Name

Gender M F

Email

Doctor/Prescriber Last Name Doctor/Prescriber Phone Number

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



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Name:	Date of Birth is required for patient identification.	Name:	
I want non-child resistant caps, when available. Failure to provide complete and accurate information may prevent		I want non-child resistant caps, when available.	
	the pharmacy from detecting drug	Date of Birth (MM/DD/YYYY)	
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	List other Allergies here:	
	Tetracycline (i.e., Doxycycline, Minocycline)		
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:	
List other OTC that you take on a regular basis:	No Over-the-Counter Medications Acetaminophen/Tylenol® Advil®/Aleve®/Motrin® Aspirin/Excedrin®	Eisrother OTC that you take on a regular basis	
s, st Moderai Dovices (see	No Medical Devices	g at Modical Devices here	
	Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.		
	No Other Prescriptions	e vergo at o okkejeget pro Wkrajio.	
Texts (a) Interested	Prescription Medications not filled		
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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.

through Express Scripts Pharmacy.

Signature Required

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.