





1042

REMEMBER: This section must be removed before mailing.

Name:

I want non-child resistant caps, when available.

Date of Birth (MM/DD/YYYY)

List other Allergies here:

List other Health Conditions here:

List other OTC that you take on a regular basis:

List Medical Devices here:

List other Prescription Medications here:

**Date of Birth is required for patient identification.**

Failure to provide complete and accurate information may prevent the pharmacy from detecting drug related problems.

**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)

**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)

**No Over-the-Counter Medications**

- Acetaminophen/Tylenol®
- Advil®/Aleve®/Motrin®
- Aspirin/Excedrin®

**No Medical Devices**

Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.

**No Other Prescriptions**

Prescription Medications not filled through Express Scripts Pharmacy.

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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.

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.