



# HOME DELIVERY PHARMACY ORDER FORM

### To MAIL your prescription:

1. "Patient" box must be filled out.
2. Have your Doctor write a prescription.
3. Send your new prescription along with this completed form to:  
Express Scripts Home Delivery Service  
PO Box 66785  
St. Louis MO 63166-6785

### To FAX your prescription:

1. Both "Dr/Prescriber" and "Rx Form" boxes must be filled out.
2. Doctor can fax to: 1-800-600-8105
  - **Class II prescriptions cannot be faxed.**
  - Faxes will only be accepted from a doctor's office.

### PATIENT

Member ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

E-mail: \_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

Health Conditions: \_\_\_\_\_

\_\_\_\_\_

Over-the-Counter Medications: \_\_\_\_\_

\_\_\_\_\_

### DOCTOR/PRESCRIBER

DEA: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

### PATIENT OPTIONS

- I want non-child resistant caps, when available.
- I want a copy of my bottle label in large print on a separate sheet of paper.
- Check here for rush delivery. Once your order is received and filled, it will be shipped overnight for \$21.

**If you want to make a payment or update your health conditions, please visit your health plan provider's website.**



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<b>Rx</b>		Date: ___ / ___ / ___	
First Name _____		Last Name _____	
<b>Drug Name/Form/Strength</b>	<b>Qty</b>	<b>Directions for Use</b>	<b>Refills</b>
<b>X</b> _____		<b>X</b> _____	
Doctor/Prescriber Signature – Substitution Permissible		Doctor/Prescriber Signature – Dispense as Written	
Stamped signatures cannot be accepted.			

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