



# WEB PRESCRIPTION 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 66558  
St. Louis MO 63166-6558

### To FAX your prescription:

1. Both "Dr/Prescriber" and "Rx Form" boxes must be filled out.
2. Doctor can fax to: 1-866-272-8856
  - **Class II prescriptions cannot be faxed.**
  - Faxed prescriptions can only be processed if submitted by a Doctor.
  - Stamped signatures cannot be accepted.

### 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 for all future orders.

I want a copy of my bottle label in large print on a separate sheet of paper.

Check here for rush shipment. Your order, once received and filled, will be shipped overnight for \$21.



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RX FORM				
Last Name		First Name		Date: ___ / ___ / ___
Drug Name/Form	Strength	Qty	Directions for Use	Refills

Doctor/Prescriber Signature – Substitution Permissible       Doctor/Prescriber Signature – Dispense as Written



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