



EXPRESS SCRIPTS®

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

PATIENT

Member ID: _____
 First Name: _____ Last Name: _____
 Date of Birth: _____ Phone: _____
 Address: _____

 E-mail: _____
 Allergies: _____
 Health Conditions: _____

 Over-the-Counter Medications: _____

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.

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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