



PRESCRIPTION ORDER FORM



To MAIL your prescription:
 1. Have your Doctor write a prescription.
 2. Send your new prescription along with this form to:
 Express Scripts
 P.O. Box 66564
 St. Louis, MO 63166-6564

To FAX your prescription:
 1. Have your Doctor fill out the bottom portion of this form.
 2. Doctor can fax to: 877-207-0438
 Class II medications cannot be faxed.
 Faxed prescription can only be processed if submitted by a Doctor.

PATIENT

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

 Email: _____
 Allergies: _____
 Health _____

 Over the Counter (OTC) _____

DOCTOR/PRESCRIBER

DEA: _____
 Name: _____
 Address: _____

 Phone: _____
 Fax: _____

PATIENT OPTIONS

I want non-child resistant caps for all future
 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



2161



121425130000



RX FORM		Last Name _____		First Name _____		Date: ___ / ___ / ___	
Drug Name/Form	Strength	Qty	Directions for Use	Refills			
X _____ Doctor/Prescriber Signature - Substitution				X _____ Doctor/Prescriber Signature - Dispense as			

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