



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
P.O. 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.



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

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