HOME DELIVERY ORDER FORM

EXPRESS SCRIPTS®

1 Member information: Please verify or provide member information below.

Member ID:

Group:

Name:

Street Address:

Street Address:

Street Address:

City, ST, ZIP:

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:

@

☐ New shipping address:

(Express Scripts will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.)

Daytime phone:

Evening phone:

FOLD HERE

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in the envelope provided.

First name

Last name

Birth date (MM/DD/YYYY)

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

FOLD HERE

3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders **payable to Express Scripts,** and write your member ID number on the front. You can enroll for e-check payments and price medications at Express-Scripts.com, or call the Member Services phone number found on your ID card.

Number of prescriptions sent with this order:

Payment options: ☐ e-check ☐ Payment enclosed ☐ Credit card ☐ Send bill

For credit card payments:
☐ Visa ☐ MC ☐ Discover ☐ Amex ☐ Diners

Credit card number

Expiration date
M M Y Y

X
Cardholder signature

☐ I authorize Express Scripts to charge this card for all orders from any person in this membership.

☐ Rush the mailing of this shipment ($21, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

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Mailing instructions are provided on the back of this form.

Patient/doctor information continued

First name | Last name

Birth date (MM/DD/YYYY) | Sex M F | Patient's relationship to member Self Spouse Dependent

Doctor's last name | 1st initial | Doctor's phone number

First name | Last name

Birth date (MM/DD/YYYY) | Sex M F | Patient's relationship to member Self Spouse Dependent

Doctor's last name | 1st initial | Doctor's phone number

FOLD HERE

Important reminders and other information

Check that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective, and less expensive generic drugs.

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

If you are a Medicare Part B beneficiary AND have private health insurance, check your prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at the phone number found on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1.800.633.4227.

Express Scripts will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise.

Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise. **Check the box if you do not wish a less expensive brand or generic drug.**

Please note that this applies only to new prescriptions and to any refills of that prescription.

For additional information or help, visit us at Express-Scripts.com or call Member Services at the phone number found on your ID card. TTY/TDD users should call 1.800.759.1089.

Federal law prohibits the return of dispensed controlled substances.

FOLD HERE

Place your prescription(s), this form, and your payment in the envelope provided. Be sure the address shows through the window. Do not use staples or paper clips.

EXPRESS SCRIPTS
PO BOX 747000
CINCINNATI, OH 45274-7000

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EXPRESS SCRIPTS®

Express Scripts Health, Allergy & Medication Questionnaire (HMQ)

Your answers to the following questions will help protect you against potentially harmful drug interactions and side effects. We will alert your pharmacist about possible drug allergies and interactions that can be harmful. To best serve you, we need to know if you have any medication allergies or medical conditions. We also need to know what prescription and nonprescription medications you take regularly.

Your privacy is important to us. Express Scripts complies with federal privacy regulations and will protect this information. Complete and return this form following the steps below or go to Express-Scripts.com/healthform to submit it online:

Step 1: Verify and complete information in SECTION 1.

Step 2: Complete all sections below using blue or black ink. Please print.

FOLD HERE

SECTION 1: Patient information

Patient name: *(First name, Last name)*

Gender: Male ○ Female ○

Date of Birth: *Month* *Day* *Year*

Contact phone:

Member number: *(Located on your member ID card and/or in your benefit information.)*

SECTION 2: Your medication allergies

Fill in the oval **completely if you have had an allergy or serious reaction to any of these medications:**

○	Aspirin and salicylates (for example: *ZORprin®*, *Trilisate®*)
○	Codeine (for example: *Tylenol®* #3)
○	Erythromycin, *Biaxin®*, *Zithromax®*
○	Nonsteroidal anti-inflammatory drugs (NSAIDS) (for example: ibuprofen, *Advil®*, *Motrin®*)
○	Penicillins/cephalosporins (for example: *Amoxil®*, amoxicillin, ampicillin, *Keflex®*, cephalexin)
○	Sulfa drugs (for example: *Septra®*, *Bactrim®*, TMP/SMX)
○	Tetracycline antibiotics

FOLD HERE

SECTION 3: Your medical supplies and equipment

Fill in the oval **completely for each medical supply or therapy that you use on a regular basis.**

○	Diabetes test strips	○	Catheters and accessories
○	Insulin pumps	○	Sleep apnea supplies
○	Ostomy bags	○	Erectile dysfunction equipment

SECTION 4: Your nonprescription medications

Fill in the oval **completely for each nonprescription medication that you are currently taking on a regular basis.**

○	*Advil®*/ibuprofen	○	*Prilosec OTC®*/omeprazole
○	*Aleve®*/naproxen	○	*Sominex®*, *Nytol®*/diphenhydramine
○	*Bayer®*/aspirin	○	*Tagamet®*/cimetidine
○	*Benadryl®*/diphenhydramine	○	*Tylenol®*/acetaminophen
○	*Orudis KT®*/ketoprofen	○	*Zantac®*/ranitidine
○	*Pepcid AC®*/famotidine		

(over, please)

Patient name: | Date of birth: Month Day Year

SECTION 5: Your medical conditions

Has your doctor ever told you that you have any of the conditions listed below? If so, fill the oval completely next to all that apply.

○	Allergies, hay fever (allergic rhinitis)	○	Heart failure (CHF)
○	Arthritis	○	Hemophilia and hemophilia-like conditions
○	Asthma	○	High blood pressure (hypertension)
○	Bladder control problem (urinary incontinence)	○	High blood sugar (diabetes)
○	Brittle bones (osteoporosis)	○	High cholesterol (hypercholesterolemia)
○	Chest pain (angina)	○	Inflammatory bowel disease
○	Crohn's disease	○	Migraine headache
○	Depression	○	Overactive thyroid (hyperthyroid)
○	Emphysema (COPD, chronic bronchitis)	○	Peptic, stomach, or duodenal ulcer
○	Enlarged prostate (benign prostatic hyperplasia, BPH)	○	Poor circulation in the legs (peripheral vascular disease)
○	Gastric reflux, heartburn, or esophagitis (GERD)	○	Seizures (epilepsy)
○	Glaucoma	○	Stroke (TIA)
○	Heart attack (myocardial infarction)	○	Underactive thyroid (hypothyroid)

Additional health information

If you have any other medication allergies, medical conditions, prescription medications not filled under your pharmacy benefit, or nonprescription medications not listed above, please call 877.438.4417.

End of Express Scripts Health, Allergy & Medication Questionnaire

Information Sharing Authorization

I hereby authorize Express Scripts to disclose to its subsidiaries and affiliates my health information in its entirety for the purpose of providing me with educational, informational, and promotional communications specific to my health. This authorization will be effective for five (5) years from the date this form is processed by Express Scripts and may be revoked by me at any time by submitting a letter in writing to Express Scripts, 4865 Dixie Highway, Fairfield, OH 45014. I understand that if I revoke this authorization it will not affect any action that Express Scripts may have taken prior to Express Scripts' receipt of the written notice of revocation. I understand that I will still be eligible for the same health plan benefits from Express Scripts whether or not I authorize information sharing. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or any other health information privacy laws. I affirm that the signature below is mine and that I am authorizing for myself or my minor dependent child named below.

Patient name:

Signature ______________________________

Did you complete both sides?

Thank you very much.

Place your completed questionnaire in the envelope marked HMQ. Do not send prescriptions, refill slips, or correspondence with this questionnaire. Be sure the address shows through the window.

HMQ PROCESSING CENTER
PO BOX 14238
LEXINGTON, KY 40512-4238