



EXPRESS SCRIPTS®

# WEB 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 66772  
St. Louis, MO 63166-6772

To FAX your prescription:

1. Have your Doctor fill out the bottom portion of this form.
2. Doctor can fax to: 866-312-7456  
Class II medications cannot be faxed.  
Faxed prescription can only be processed if submitted by a Doctor.

### PATIENT

Member ID: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

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



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<b>RX FORM</b>		Last Name _____		First Name _____		Date: ___ / ___ / ___	
Drug Name/Form	Strength	Qty	Directions for Use		Refills		
<input checked="" type="checkbox"/> Doctor/Prescriber Signature - Substitution				<input checked="" type="checkbox"/> Doctor/Prescriber Signature - Dispense as			

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Express Scripts Inc.

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