



# 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 66773  
 St. Louis, MO 63166-6773

To FAX your prescription:  
 1. Have your Doctor fill out the bottom portion of this form.  
 2. Doctor can fax to: 800-521-5779  
 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



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

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