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 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

2161

896415093300

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