





1042

### Patient 1 (Cardholder)

Name: \_\_\_\_\_

I want non-child resistant caps, when available.

Date of Birth (MM/DD/YYYY)

□□ / □□ / □□□□

**Date of Birth is required for patient identification.**

Failure to provide complete and accurate information may prevent the pharmacy from detecting drug related problems.

### Patient 2

Name: \_\_\_\_\_

I want non-child resistant caps, when available.

Date of Birth (MM/DD/YYYY)

□□ / □□ / □□□□

REMINDER: This section must be removed before mailing.

<b>DRUG ALLERGIES</b>	<b>List other Allergies here:</b>	<input type="radio"/> <b>No Known Allergies</b>	<b>List other Allergies here:</b>
	<input type="radio"/>	Acetaminophen/Tylenol®	<input type="radio"/>
	<input type="radio"/>	Amoxicillin	<input type="radio"/>
	<input type="radio"/>	Aspirin	<input type="radio"/>
	<input type="radio"/>	Cephalosporin (i.e., Keflex®, Cephalexin)	<input type="radio"/>
	<input type="radio"/>	Codeine	<input type="radio"/>
<input type="radio"/>	Erythromycin, Biaxin®, Zithromax®	<input type="radio"/>	
<input type="radio"/>	NSAIDs (i.e., Ibuprofen, Naproxen)	<input type="radio"/>	
<input type="radio"/>	Oxycodone (i.e., OxyContin®, Percocet®)	<input type="radio"/>	
<input type="radio"/>	Penicillin	<input type="radio"/>	
<input type="radio"/>	Sulfa	<input type="radio"/>	
<input type="radio"/>	Tetracycline (i.e., Doxycycline, Minocycline)	<input type="radio"/>	
<b>HEALTH CONDITIONS</b>	<b>List other Health Conditions here:</b>	<input type="radio"/> <b>No Known Health Conditions</b>	<b>List other Health Conditions here:</b>
	<input type="radio"/>	Arthritis (715.9)	<input type="radio"/>
	<input type="radio"/>	Asthma (493.9)	<input type="radio"/>
	<input type="radio"/>	Chronic Bronchitis or Emphysema (496)	<input type="radio"/>
	<input type="radio"/>	Depression (311)	<input type="radio"/>
	<input type="radio"/>	Diabetes Type I (250.01)	<input type="radio"/>
	<input type="radio"/>	Diabetes Type II (250.00)	<input type="radio"/>
	<input type="radio"/>	Epilepsy/Seizures (345.9)	<input type="radio"/>
	<input type="radio"/>	GERD (530.81)	<input type="radio"/>
	<input type="radio"/>	Glaucoma (365.9)	<input type="radio"/>
	<input type="radio"/>	High Cholesterol (272.9)	<input type="radio"/>
	<input type="radio"/>	Hormone Replacement Therapy (627.9)	<input type="radio"/>
	<input type="radio"/>	Hypertension (401.9)	<input type="radio"/>
<input type="radio"/>	Thyroid: Low (244.9)	<input type="radio"/>	
<b>OTC</b>	<b>List other OTC that you take on a regular basis:</b>	<input type="radio"/> <b>No Over-the-Counter Medications</b>	<b>List other OTC that you take on a regular basis:</b>
	<input type="radio"/>	Acetaminophen/Tylenol®	<input type="radio"/>
	<input type="radio"/>	Advil®/Aleve®/Motrin®	<input type="radio"/>
	<input type="radio"/>	Aspirin/Excedrin®	<input type="radio"/>
<b>DEVICES</b>	<b>List Medical Devices here:</b>	<input type="radio"/> <b>No Medical Devices</b>	<b>List Medical Devices here:</b>
	<input type="radio"/>	Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.	<input type="radio"/>
<b>OTHER</b>	<b>List other Prescription Medications here:</b>	<input type="radio"/> <b>No Other Prescriptions</b>	<b>List other Prescription Medications here:</b>
	<input type="radio"/>	Prescription Medications not filled through Express Scripts Pharmacy.	<input type="radio"/>

FDA approved generic medications will be dispensed when allowed by your doctor, subject to the terms outlined in your plan. I certify that all the information on this form is correct. I permit Express Scripts Inc. to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment or health care operations.

Signature Required  \_\_\_\_\_

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