



INSTRUCTIONS FOR PLACING YOUR ORDER

Contact your doctor to write a new prescription for up to a three-month supply with authorized refills for up to one year.

OPTION 1: MAIL Your Order

1. Complete the New Patient Mail Order Form enclosed.
2. Attach your prescriptions to the order form.
3. Mail the New Patient Mail Order Form and your prescriptions to:

Express Scripts, Inc.
PO Box 52150
Phoenix, AZ 85072-9954

CLIENT ID:
DOD



OPTION 2: FAX Your Order

1. Complete the New Patient Mail Order Form enclosed.
2. Ask your doctor to fax the New Patient Order Form and your written prescriptions to:

FAX: 1-877-895-1900 (OVERSEAS FAX: 1-602-586-3911)

**Legally, we can only accept a faxed prescription from your DOCTOR'S OFFICE.
Faxes sent from other locations (such as your home or workplace) will not be accepted.**

**DOCTOR NOTE: We cannot accept Schedule II controlled substances by fax.
All prescriptions for these medications must be mailed.**



PLEASE PRINT IN ALL CAPITAL LETTERS USING BLACK INK.

IF THERE ARE MORE THAN 3 FAMILY MEMBERS, WRITE THE INFORMATION ON A SEPARATE PIECE OF PAPER.

1. PERSONAL INFORMATION

SPONSOR

ID NUMBER _____

FIRST NAME _____ M.I. _____

LAST NAME _____

DRUG ALLERGIES (CHECK ALL THAT APPLY) PENICILLIN (01) _____ ASPIRIN (03) _____ CODEINE (04) _____ SULFA (15) _____

TETRACYCLINE (07) _____ ERYTHROMYCIN (09) _____ OTHER: _____

NO KNOWN DRUG ALLERGIES (00) _____ BIRTH DATE _____ - _____ - _____ GENDER _____
M M D D Y Y

MAILING: YOU MUST PROVIDE A U.S. POSTAL ADDRESS. PRESCRIPTIONS CANNOT BE MAILED TO PRIVATE FOREIGN ADDRESSES.

(U.S. POSTAL ADDRESS, INCLUDING APO/FPO) _____

CITY _____

STATE _____ ZIP CODE _____ - _____ CLIENT ID: DOD

PHONE # _____ - _____ - _____

PHYSICIAN LAST NAME _____



PHYSICIAN PHONE # _____ - _____ - _____



FAMILY MEMBER 1

FIRST NAME _____ M.I. _____

LAST NAME _____

DRUG ALLERGIES (CHECK ALL THAT APPLY) PENICILLIN (01) _____ ASPIRIN (03) _____ CODEINE (04) _____ SULFA (15) _____

TETRACYCLINE (07) _____ ERYTHROMYCIN (09) _____ OTHER: _____

NO KNOWN DRUG ALLERGIES (00) _____ BIRTH DATE _____ - _____ - _____ GENDER _____
M M D D Y Y

PHYSICIAN LAST NAME _____

PHYSICIAN PHONE # _____ - _____ - _____

FAMILY MEMBER 2

FIRST NAME _____ M.I. _____

LAST NAME _____

DRUG ALLERGIES (CHECK ALL THAT APPLY) PENICILLIN (01) _____ ASPIRIN (03) _____ CODEINE (04) _____ SULFA (15) _____

TETRACYCLINE (07) _____ ERYTHROMYCIN (09) _____ OTHER: _____

NO KNOWN DRUG ALLERGIES (00) _____ BIRTH DATE _____ - _____ - _____ GENDER _____
M M D D Y Y

PHYSICIAN LAST NAME _____

PHYSICIAN PHONE # _____ - _____ - _____

FAMILY MEMBER 3

FIRST NAME _____ M.I. _____

LAST NAME _____

DRUG ALLERGIES (CHECK ALL THAT APPLY) PENICILLIN (01) _____ ASPIRIN (03) _____ CODEINE (04) _____ SULFA (15) _____

TETRACYCLINE (07) _____ ERYTHROMYCIN (09) _____ OTHER: _____

NO KNOWN DRUG ALLERGIES (00) _____ BIRTH DATE _____ - _____ - _____ GENDER _____
M M D D Y Y

PHYSICIAN LAST NAME _____

PHYSICIAN PHONE # _____ - _____ - _____

2. PAYMENT METHOD

STANDARD DELIVERY OF YOUR ORDER IS FREE. YOUR ORDER WILL ARRIVE WITHIN 14 DAYS FROM THE DATE WE RECEIVE YOUR ORDER. PLEASE INCLUDE PAYMENT WITH YOUR ORDER. DO NOT SEND CASH.

TO EXPEDITE SHIPPING, YOU MAY CHOOSE TO HAVE YOUR ORDER SENT BY NEXT-DAY DELIVERY, AFTER IT IS PROCESSED, FOR AN ADDITIONAL CHARGE OF \$21. (NOTE: THIS WILL ONLY AFFECT SHIPPING TIME, NOT THE PROCESSING OF YOUR ORDER.)

NOTE: YOUR CREDIT CARD WILL BE CHARGED ACCORDANCE WITH YOUR PRESCRIPTION PLAN. ALL FUTURE ORDERS WILL BE CHARGED TO THIS CREDIT CARD, UNLESS PAYMENT (CHECK) ACCOMPANIES THE ORDER.

CREDIT CARD # _____

CLIENT ID:
DOD

CARDHOLDER

NAME _____
PLEASE PRINT NAME AS IT APPEARS ON CREDIT CARD

EXPIRATION DATE _____ - _____
M M Y Y



AUTHORIZED SIGNATURE

NOTE: IF PAYING BY CHECK OR MONEY ORDER, PLEASE REFER TO YOUR PRESCRIPTION PLAN MATERIALS FOR COPY.

CHECK/MONEY ORDER _____ AMOUNT ENCLOSED \$ _____ . _____

3. SIGNATURE REQUIRED

PLEASE CHECK ANY OF THE TWO OPTIONS (IF APPLICABLE) AND SIGN THE FOLLOWING STATEMENT.

_____ I WOULD LIKE MY PRESCRIPTIONS DISPENSED WITH
NON-CHILD RESISTANT (EASY OPEN) CAPS.

_____ I REQUEST THAT THIS AND FUTURE ORDERS BE SHIPPED
"SIGNATURE REQUIRED" FOR AN ADDITIONAL CHARGE.

I CERTIFY THAT ALL THE INFORMATION ON THIS FORM IS CORRECT, INCLUDING ANY SELECTIONS MADE FOR SENDING MY ORDER SIGNATURE REQUIRED OR WITH NON-CHILD RESISTANT (EASY OPEN) CAPS. 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.

AUTHORIZED SIGNATURE

4. REVIEW YOUR PRESCRIPTION

AS REQUIRED BY THE U.S. DEPARTMENT OF DEFENSE, WE WILL DISPENSE FDA APPROVED GENERIC MEDICATIONS UNLESS YOUR PHYSICIAN ESTABLISHES THAT THE BRAND-NAME MEDICATION IS MEDICALLY NECESSARY.

- PLEASE HAVE YOUR PHYSICIAN PRESCRIBE UP TO THE MAXIMUM DAYS SUPPLY ALLOWED. (A 90-DAY SUPPLY FOR MOST MEDICATIONS)
- CHECK TO SEE IF THE PATIENT NAME, ADDRESS AND DATE OF BIRTH IS CLEARLY WRITTEN ON THE PRESCRIPTION. IF NOT, PRINT THE PATIENT'S FULL NAME, ADDRESS, PHONE NUMBER AND DATE OF BIRTH ON THE BACK OF THE PRESCRIPTION.
- CHECK TO SEE IF THE PHYSICIAN SIGNATURE IS LEGIBLE AND PHYSICIAN PHONE NUMBER IS PRINTED ON THE PRESCRIPTION. IF NOT, PLEASE CIRCLE THE PHYSICIAN'S NAME ON THE PRESCRIPTION, OR PRINT THE PHYSICIAN NAME AND PHONE NUMBER, INCLUDING AREA CODE ON THE BACK OF THE PRESCRIPTION.

HEARING IMPAIRED: 1.877.540.6261 TOLL-FREE: 1.877.363.1303
FOR REFILLS: www.express-scripts.com