

Ordering Your Prescriptions Is as Easy as Point. Click. Order.

Register today at www.StartHomeDelivery.com
and enjoy the convenience of our online services.

- Order and refill your prescriptions
- Track the status of your orders
- Learn more about your prescription-drugs benefits
- Get the latest prescription-drug, health and wellness information



Get Started Today
Complete and detach this form,
and bring it or fax it to your
doctor to begin receiving your
prescriptions by mail.



EXPRESS SCRIPTS®

One Express Way
St. Louis, MO 63121

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save money and time
PRESCRIPTIONS BY MAIL



Your Fast, Economical Option for Long-Term Prescriptions

Do you take prescription medications on a long-term basis for conditions such as asthma, diabetes, high cholesterol, hypertension or arthritis? You may not know that one of the benefits of your Express Scripts membership is having medications delivered right to your door at no additional charge. Besides saving you trips to your local pharmacy, Home Delivery from the Express Scripts Pharmacy offers you a number of valuable advantages.



The Benefits Are in the Mail

Save Money

With Home Delivery from the Express Scripts Pharmacy, you could receive up to a three-month supply of your medication for the cost of a two and a half-month copayment at a participating pharmacy. That's a savings of up to 33%.

Free Home Delivery

Once you and your doctor complete the attached form and your doctor faxes it to Express Scripts, your prescription will be filled, shipped and delivered to your home or office, FREE of shipping costs, within 10 to 14 days.

Safe and Reliable

A registered pharmacist checks every order, and your prescriptions are shipped in plain, weather-resistant pouches for your privacy and protection.

Professional Service

A registered pharmacist is available to answer your questions anytime day or night.

Easy to Use

Just fill out the attached form and have your doctor fax it to Express Scripts. Once you begin using Home Delivery, you can order your refills online at www.StartHomeDelivery.com or by phone.

www.StartHomeDelivery.com



EXPRESS SCRIPTS®

Fax to: Express Scripts (Bensalem)
MD fax #: 800.636.9494
(Fax not valid for Schedule II prescriptions)

TO ORDER PRESCRIPTIONS BY MAIL

Step 1: Complete the Patient Information, Payment Information and Allergy Information sections. A separate form must be used for each prescription.

Patient Information	Payment Information
Name: _____	(No payment is due for a Workers' Compensation claim.)
Member ID: _____	<input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Discover <input type="checkbox"/> American Express
Date of Birth: _____	Cardholder Name: _____
Address: _____	Card Number: _____
Day Phone: (____) _____	Expiration Date: _____
Evening Phone: (____) _____	Cardholder Signature: _____
E-mail Address: _____	<i>Note: All future orders will be charged to this credit card.</i>
<input type="checkbox"/> Send my prescription via overnight delivery. (Additional \$18 will be charged to your credit card.)	
Allergy Information (Please mark an X in the appropriate box for any allergies.)	
<input type="checkbox"/> No known allergies	<input type="checkbox"/> Sulfa Type Drugs (Bactrim®, Septra®, Glyburide, Glucotrol®, Glipizide, Micronase®, others)
<input type="checkbox"/> Penicillins (Ampicillin, Amoxicillin, others)	<input type="checkbox"/> Aspirin and non-steroidal pain relievers (Aspirin, Ibuprofen, Naproxen, Relafen®, Daypro®, Celebrex®)
<input type="checkbox"/> Cephalosporins (Keflex®, Velosef®, Suprax®, Vantin®, Ceclor®, Cefzil®, others)	
Other health conditions, medications and drug allergies _____	

Step 2: Take this form to your doctor. Have your doctor complete the Doctor Information and Prescription Information sections.

Doctor Information	
Name: _____	DEA Registration Number: _____
Address: _____	Phone: (____) _____
Fax: (____) _____	Alternate Office Contact(s): _____
Date: _____	_____

To save money, we will dispense FDA-approved generic medications when allowed by your doctor, subject to the terms outlined in your plan.

Prescription Information (90-day supply plus refills for up to one year, if appropriate)		
Drug Name: _____	Directions: _____	
	Qty. _____	
Refill: _____ times	Dr. _____	Dr. _____
	Substitution permitted	Dispense as written

Step 3: Have your doctor or a member of your doctor's staff fax this form **from the doctor's office** to 800.636.9494. Faxes from other locations will not be accepted.

Your prescription will be delivered within 10 to 14 days from receipt of your order.