



INSTRUCTIONS FOR PLACING YOUR ORDER

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

OPTION 1: MAIL Your Order

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

Express Scripts, Inc.
Mail Pharmacy Service
PO BOX 52127
PHOENIX, AZ 85072-2127

Client ID:
ANCHOR/MHY



OPTION 2: Have your physician FAX Your Order

1. Complete the New Patient Home Delivery Form enclosed.
2. Ask your physician to fax the New Patient Home Delivery and your prescriptions to:

Fax Number: 1-800-613-5628

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

PHYSICIAN NOTE: CII prescriptions cannot be faxed. 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

CARDHOLDER (REFER TO YOUR PLAN CARD)

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 _____

PLEASE PROVIDE A STREET ADDRESS. CERTAIN MEDICATIONS CANNOT BE DELIVERED TO A POST OFFICE BOX.

MAILING ADDRESS _____

CITY _____

STATE _____ ZIP CODE _____ - _____

PHONE # _____ - _____ - _____ (Your phone number is used to provide information about your order)

Client ID: ANCHOR/MHY



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 _____

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 _____

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

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

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

CHECK CARD _____ CREDIT CARD _____

CARD # _____

CARDHOLDER NAME _____
PLEASE PRINT NAME AS IT APPEARS ON CREDIT CARD

EXPIRATION DATE ____-____-____
M M Y Y

Client ID:
ANCHOR/MHY



AUTHORIZED SIGNATURE

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

PRESCRIPTIONS THAT DO NOT INCLUDE THE INFORMATION BELOW MAY BE DELAYED OR RETURNED TO YOU UNFILLED.

PHYSICIAN INFORMATION: NAME • SIGNATURE • DEA NUMBER. IF THERE ARE MULTIPLE PHYSICIANS, CIRCLE YOUR PHYSICIAN'S NAME.

PATIENT INFORMATION: FIRST AND LAST NAME • ADDRESS • DATE OF BIRTH • ID NUMBER.

PRESCRIPTION INFORMATION: DATE WRITTEN • DRUG NAME • STRENGTH • MEDICATION DIRECTIONS • QUANTITY NUMBER OF REFILLS.

QUESTIONS ABOUT YOUR PHARMACY BENEFIT?
CALL THE CUSTOMER SERVICE NUMBER THAT WAS PROVIDED TO YOU.