HOME DELIVERY ORDER FORM

EXPRESS SCRIPTS®

1 Member information: Please verify or provide member information below.

Member ID: _____
Group: _____
Name: _____
Street Address: _____
Street Address: _____
Street Address: _____
City, ST, ZIP: _____

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:
_____@_____.____

☐ New shipping address:

_____

_____

_____

(Express Scripts will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.)

Daytime phone: ☐☐☐ ☐☐☐ ☐☐☐☐

Evening phone: ☐☐☐ ☐☐☐ ☐☐☐☐

FOLD HERE

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in the envelope provided.

First name ☐☐☐☐☐☐☐☐☐☐☐☐☐

Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birth date (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

1st initial ☐

Doctor's phone number ☐☐☐ ☐☐☐ ☐☐☐☐

First name ☐☐☐☐☐☐☐☐☐☐☐☐☐

Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Birth date (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

1st initial ☐

Doctor's phone number ☐☐☐ ☐☐☐ ☐☐☐☐

FOLD HERE

3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders **payable to Express Scripts,** and write your member ID number on the front. You can enroll for e-check payments and price medications at Express-Scripts.com, or call the Member Services phone number found on your ID card.

Number of prescriptions sent with this order: ☐

Payment options: ☐ e-check ☐ Payment enclosed ☐ Credit card ☐ Send bill

For credit card payments:
☐ Visa ☐ MC ☐ Discover ☐ Amex ☐ Diners

Credit card number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration date ☐☐ ☐☐
M M Y Y

X _____
Cardholder signature

☐ I authorize Express Scripts to charge this card for all orders from any person in this membership.

☐ Rush the mailing of this shipment ($21, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

MLRFOHNW

Mailing instructions are provided on the back of this form.

Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Sex
☐ M ☐ F

Patient's relationship to member
☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex
☐ M ☐ F

Patient's relationship to member
☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

FOLD HERE

Important reminders and other information

Check that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective, and less expensive generic drugs.

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

If you are a Medicare Part B beneficiary AND have private health insurance, check your prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at the phone number found on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1.800.633.4227.

Express Scripts will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise.

☐ Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise.

Check the box if you do not wish a less expensive brand or generic drug.

Please note that this applies only to new prescriptions and to any refills of that prescription.

For additional information or help, visit us at Express-Scripts.com or call Member Services at the phone number found on your ID card. TTY/TDD users should call 1.800.759.1089.

Federal law prohibits the return of dispensed controlled substances.

FOLD HERE

Place your prescription(s), this form, and your payment in the envelope provided. Be sure the address shows through the window. Do not use staples or paper clips.

EXPRESS SCRIPTS
PO BOX 747000
CINCINNATI, OH 45274-7000

Health, Allergy & Medication Questionnaire (HMQ)

EXPRESS SCRIPTS®

Your answers to the following questions will help us provide your prescription drug benefit services, including filling prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know if you have any known allergies, conditions, or diseases.

- Please complete the questionnaire for each person in the household eligible for pharmacy benefits through **the Medco Pharmacy®**, now a part of the Express Scripts family of pharmacies.
- If you need additional forms, you may call your Highmark Member Service toll-free number, or you may print a form online at **www.highmarkbcbs.com**.
- **Return this questionnaire with your prescription or refill order form.**

Section 1: Member Identification and Contact

Group Number

Member Number
(Located on your current ID card or in your benefit information)

Area Code
Daytime Telephone Number

Member/Subscriber First Name

M.I.

Last Name

Street Address/Apt. No.

City

State

Zip

Section 2: Drug Allergy Conditions

For each covered family member, include their name, date of birth and gender.
For each family member, fill in the circle **ONLY** if an allergy or bad reaction happened anytime in the past. If your medication is not listed, please print the name of the medication allergy in the bottom section of this chart.
Correct way to mark circles: ● Please use blue or black ink.

	Member	**Spouse**	**Dependent**	**Dependent**	**Dependent**
First Name:					
Add last name if different than member					
Date of Birth:	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Gender:	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F
Penicillin/cephalosporin antibiotics (e.g., ampicillin, Keflex®)	○	○	○	○	○
Tetracycline antibiotics	○	○	○	○	○
Erythromycin, Biaxin®, Zithromax®	○	○	○	○	○
Codeine (e.g., Tylenol #3®)	○	○	○	○	○
Nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen)	○	○	○	○	○
Aspirin (e.g., salicylates)	○	○	○	○	○
Sulfa drugs	○	○	○	○	○
Iodine	○	○	○	○	○
Print other drug allergies not listed above in the space provided (e.g., morphine)					

Continued on back

Section 3: Medical Conditions

Please list in the appropriate column the names of each family member enrolled. Then, for each family member, fill in the circle next to each condition if a doctor ever said ***that particular family member*** has that condition.

First Name:	Member	Spouse	Dependent	Dependent	Dependent
Heart failure (weak heart)	○	○	○	○	○
High blood pressure (hypertension)	○	○	○	○	○
Heart attack or angina	○	○	○	○	○
High cholesterol (hypercholesterolemia)	○	○	○	○	○
Stroke	○	○	○	○	○
Chronic bronchitis or emphysema (COPD)	○	○	○	○	○
Asthma	○	○	○	○	○
Allergies, runny nose, hay fever (allergic rhinitis)	○	○	○	○	○
High blood sugar (diabetes)	○	○	○	○	○
Thyroid disease	○	○	○	○	○
Peptic, stomach, or duodenal ulcer	○	○	○	○	○
Gastric reflux, heartburn, or esophagitis (GERD)	○	○	○	○	○
Inflammatory bowel disease (colitis, Crohn's disease)	○	○	○	○	○
High pressure in the eyes (glaucoma)	○	○	○	○	○
Seizures	○	○	○	○	○
Poor circulation in the legs (peripheral vascular disease)	○	○	○	○	○
Trouble with blood not clotting properly	○	○	○	○	○
Enlarged prostate (benign prostatic hyperplasia, BPH)	○	○	○	○	○
Arthritis	○	○	○	○	○
Osteoporosis	○	○	○	○	○
Depression	○	○	○	○	○
Migraine Headaches	○	○	○	○	○
Print other medical conditions not listed above in the space provided (e.g., cancer)					

Please return the questionnaire with your prescription or refill order form.

Did you complete both sides? **Thank you very much.**