





1042

**Patient 1 (Cardholder)**

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

I want non-child resistant caps for all future prescriptions.

Date of Birth (MM/DD/YYYY)  
  /   /

It is very important that you fill in the table below as shown (●).

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 for all future prescriptions.

Date of Birth (MM/DD/YYYY)  
  /   /

<b>DRUG ALLERGIES</b>	List other Allergies here: <input type="radio"/>	<b>No Known Allergies</b>	<input type="radio"/> List other Allergies here:
	<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>	List other Health Conditions here: <input type="radio"/>	<b>No Known Health Conditions</b>	<input type="radio"/> List other Health Conditions here:
	<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>	List other OTC that you take on a regular basis: <input type="radio"/>	<b>No Over-the-Counter Medications</b>	<input type="radio"/> List other OTC that you take on a regular basis:
	<input type="radio"/>	Acetaminophen/Tylenol®	<input type="radio"/>
	<input type="radio"/>	Advil®/Aleve®/Motrin®	<input type="radio"/>
<b>DEVICES</b>	List Medical Devices here: <input type="radio"/>	<b>No Medical Devices</b>	<input type="radio"/> List Medical Devices here:
	<input type="radio"/>	List Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.	<input type="radio"/>
<b>OTHER</b>	List other Prescription Medications here: <input type="radio"/>	<b>No Other Prescriptions</b>	<input type="radio"/> List other Prescription Medications here:
	<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  \_\_\_\_\_

PENNSYLVANIA LAW PERMITS PHARMACISTS TO SUBSTITUTE A LESS EXPENSIVE GENERICALLY EQUIVALENT DRUG FOR A BRAND NAME DRUG UNLESS YOU OR YOUR PHYSICIAN DIRECT OTHERWISE.

I DO NOT WANT A LESS EXPENSIVE BRAND OR GENERIC DRUG PRODUCT. I UNDERSTAND THAT BY SELECTING THIS STATEMENT, I MAY INCUR ADDITIONAL COSTS ACCORDING TO THE GUIDELINES OF MY PRESCRIPTION PLAN. WRITE 'BRAND ONLY' ON THE BACK OF ANY PRESCRIPTION YOU WANT TO RECEIVE AS A BRAND MEDICATION.

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