PLEASE PRINT **Complete all 5 sections to order your medications** FOLD OVER AND SEAL

Section 1 **You only need to complete this section for a covered family member the first time the person orders medication, unless any information changes.** In the Comments area at right, list all medications being taken by each family member ordering medication so we can review for potential interactions. Provide additional information on a separate sheet if necessary. If anyone goes by a nickname, please write the name in the appropriate space below.

Member's I.D. Number

If anyone has other insurance coverage, please enter name of insurance company and check box below.

Insurance company

Allergies: Please mark an "X" in the appropriate box for any allergies you or others listed on the form may have.

Member	Acetaminophen (Tylenol)	Alcohol	Ampicillin	Aspirin	Cephalosporin Antibiotics (Keflex, Duricef, etc.)	Codeine	Erythromycin	Local anesthetics	Morphine and Derivatives	Penicillin	Propoxyphene (Darvon, Darvocet, etc.)	Sulfa	Sulfonamide Derivatives (Gantrisin, Gantanol, etc.)	Tegracyclines	Comments
Member															List below any other **allergies** and all medications, including over-the-counter medications, each person is currently taking. Also list any illnesses or medical conditions (i.e., asthma, blood pressure). Use a separate sheet if necessary.
Spouse															
Dependent															
Dependent															

Name Last First M.I. Nickname

Sex: ☐M ☐F ☐No known allergies ☐Other Ins. Coverage

Physician _ _ Birth Date

☐Smoker ☐Pregnant ☐Contact Lenses ☐Drink Alcohol

FOLD BOTTOM OF PAGE TO LINE TO CREATE SLOT FOR INSERTING PRESCRIPTION(S)

SEAL THIS GRAYED ZONE BEFORE MAILING ORIGINAL WRITTEN PRESCRIPTION(S)

SEAL THIS GRAYED ZONE BEFORE MAILING ORIGINAL WRITTEN PRESCRIPTION(S)

FOLD LINE

PLACE STAMP HERE

☐ PLEASE CHECK HERE FOR CHANGE OF ADDRESS

UNIVERSITY OF MISSOURI SYSTEM
MAIL PHARMACY SERVICE
PO BOX 66773
SAINT LOUIS, MO 63166-6773

Express Scripts
Progressive Healthcare Management

BENEFITS

- **Standard postage paid**
- **Convenient home delivery with 14 days**
- **Free drug interaction screening**
- **Pharmacist available 24 hours**
- **24 hour touch-tone service available for refills or to check status on refills**
- **MC, VISA and DISCOVER accepted**

Questions & Answers

1. WHEN DO I USE MAIL SERVICE?
Mail service should be used for ordering medications you will take for more than 30 days.

2. WHAT CAN I DO TO EXPEDITE PROCES–SING OF THE PRESCRIPTION(S)?

Is the name clearly written on the prescription? If not, please print the patient's full name, address and phone number on back of the prescription.

Is the doctor's signature legible and is the office phone number on the prescription?
If not, please circle the doctor's name on prescription blank or print the name clearly on the back of the prescription, along with a phone number.

Are the directions and quantities on the prescriptions clear?
If the doctor writes "As directed," this could delay your order.

Does the patient's condition require long term therapy?
If so, ask the doctor to write the prescription for the maximum quantity allowed by the prescription plan. Make sure the doctor allows for generic substitution as this maximizes your healthcare dollar!

Have you completely filled out the attached mailer envelope including evening phone number, if different from your daytime phone number?
This helps us if it is necessary to contact you.

3. WHY ARE THE PATIENT'S ALLERGIES AND HEALTH CONDITIONS IMPORTANT?
Registered pharmacists review the patient's record prior to filling the prescriptions to identify potential adverse reactions and interaction problems.

4. HOW DO I TRANSFER MY PRESCRIPTIONS TO EXPRESS SCRIPTS?
Call the doctor's office and request a new prescription for the maximum days supply allowed by the prescription plan and mail it to: **Express Scripts, Attn: Mail Pharmacy, Box 66773, St. Louis, MO 63166-6773.**

OTHER QUESTIONS:
Please Call
Customer Service
1-800-955-1201

PLEASE ALLOW 2 WEEKS FOR DELIVERY

Hearing Impaired:
TDD# 1-800-972-4348

Customer Service:
1-800-955-1201
7:30 a.m. - 10:00 p.m. M-F: 10:00 a.m.-4:00 p.m. Sat. CST.
(Your call will be expedited by calling Tues.-Fri. after 1 p.m. **CST)**

Telephone Refills:
1-800-945-5979

Section 2 **To order:** Enclose your original written prescription(s). If you are already taking a medication, call your doctor's office and request a new prescription for the maximum days supply allowed by your health plan. ***IMPORTANT: TO AVOID DELAY - PLEASE ENCLOSE CHECK, MONEY ORDER OR CREDIT CARD NUMBER FOR PROCESSING.***

Section 3 Complete this section indicating how you wish to pay for your medication. **Please do not send cash**

☐ Check or money order enclosed — Amount Enclosed $. — Check Number
☐ Charge to my credit card
☐ Charge this and all future orders to this credit card — Cardholder Name — Account Number
Cardholder Signature — Expiration Date — ☐ Master Card ☐ VISA ☐ Discover Card

Section 4 **Tell us where to ship your order**

☐ Check here for address change

Name — Last — First — M.I. — Member I.D. Number — Daytime Phone ( )
Mailing Address — Street — P.O. Box — Apt. No. — City — State — Zip Code
Doctor's Phone ( ) — Doctor's Name Dr. — Group/ Employer Name — Date — Home Phone ( )

Section 5

Special Handling Required:

Non-Child-Resistant Containers
Please sign below if you want prescriptions for you or your eligible dependents dispensed in non-child-resistant containers.

X
Signature Required

If you wish to resume receiving child-resistant containers, please check box.

Express Scripts
Progressive Healthcare Management

I request this and all future orders to shipped "signature required". I understand there will be an extra charge for this service.

X
Signature Required

I certify that all information on this form is correct. I permit Express Scripts to release all information to plan sponsor, administrator or underwriter.

MKMLB63 12/99 - F&S/BB