Mail your completed order form, original prescription(s) and payment to: NextRx, PO Box 746000, Cincinnati, OH 45274-6000.
If you have multiple prescriptions, include all prescriptions with the order form. You may duplicate the order form as needed.

## SECTION 1: MEMBER INFORMATION

Provide policy or cardholder information as found on the health plan or benefit card. Please do not write on the back of form.

**Name of Your Health Plan** | **Identification Number**

**Policy or cardholder last name** | **First name** | **Initial** | **Date of birth (MM/DD/YYYY)** / /

## SECTION 2: SHIPPING INFORMATION

Orders ship within seven days of receipt of valid order. Controlled and refrigerated medications cannot ship to a PO box. Schedule II controlled substances require signature on delivery.

**New address** ☐ Y ☐ N **Permanent address** ☐ Y ☐ N | **Street address** | **Apartment/suite**

**City** | **State** | **ZIP code** | **Daytime phone # (including area code)**

**E-mail address** | **Evening phone # (including area code)**

## SECTION 3: PAYMENT INFORMATION

Payment is required before an order will ship. Do not send cash. Make checks and money orders payable to NextRx. There is a $25 fee for returned checks. Credit cards are charged for the entire order and used for future orders unless a new payment method is specified. Overnight shipping does not expedite prescription processing time.

**Payment method:** ☐ Check ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover ☐ Overnight Shipping (add $20)

**Account number** | **Expiration date** | **Signature/date**

**Amount enclosed:** | **Coupon Code:**

## SECTION 4: PRESCRIPTION INFORMATION

Federally approved, generic-equivalent medications will be dispensed for brand name medications unless otherwise directed by the patient, physician, or health plan. If you require brand medications, please use the comments section below and list the names of the medications. Brand may be subject to higher cost.

**Patient last name** | **First name** | **Initial** | **Patient date of birth (MM/DD/YYYY)** / / | **Patient gender** ☐ M ☐ F

**Drug allergies (check all that apply):** ☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Sulfa

☐ **Other (list all, including over-the-counter medications)**

**Medical history (check all that apply):** ☐ Diabetes ☐ Glaucoma ☐ High blood pressure ☐ Arthritis

☐ Thyroid ☐ Heart condition ☐ Asthma ☐ Other (list all)

| New prescription: medication name | Doctor last name | Taken before | PLACE ON PROFILE |
|---|---|---|---|
| | | ☐ Y ☐ N | ☐ (will order when needed) |
| | | ☐ Y ☐ N | ☐ |
| | | ☐ Y ☐ N | ☐ |

| Refill orders: Rx refill # | Medication name | Refill orders: Rx refill # | Medication name |
|---|---|---|---|
| | | | |
| | | | |

**Comments**

**Language translation services available at 877-373-6770. NextRx, PO Box 746000, Cincinnati, OH 45274-6000.** Express Scripts, Inc. (ESI) is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members. WellPoint NextRx, NextRx and PrecisionRx are registered trademarks of WellPoint, Inc. and are used under license agreement by ESI.