



Today's Date :

Secure server URL: <https://DPP.express-scripts.com> (e-mail : DeployedPrescriptionProgram@express-scripts.com for instructions)

Fax To: 877-327-8038

Mail To: PO Box 52012 Phoenix, AZ 85072-2012

Center/Theater Name:

** All Information REQUIRED - please indicate if N/A. Insufficient information may result in prescription delays.

Patient Information

Last Name:

First Name:

MI:

Date of Birth
(MM/DD/YYYY):

Full SSN:

Gender:

Mailing Address:

Email Address:

Active Fill (if the box is not checked, the fill will be pended until the patient releases it via the web)

Allergies (Check In Category That Applies)

No Known Drug Allergies Known Drug Allergies Specify:

Drug Name and Formulation	Strength	Form	Quantity	Directions	Refills

** All Credentials REQUIRED - please indicate if N/A. Insufficient credentials may result in prescription delays.

Supervising Physician for Prescriber

Email Address:

NPI#:

State License #:

DEA# (Required for controlled drugs):

Name:

Signature:



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