



MEDICATION REFILL REQUEST FORM

****Orders must be received 2 HOURS prior to the daily scheduled delivery****

Refill Sticker	Refill Sticker	Refill Sticker			
Refill Sticker	Refill Sticker	Refill Sticker			
Refill Sticker	Refill Sticker	Refill Sticker			
Refill Sticker	Refill Sticker	Refill Sticker			
Refill Sticker	Refill Sticker	Refill Sticker			
Patient Name	Medication	Rx #	Qty on hand	Rx Status	
Patient Name	Medication	Replacement Dose Date/Time of Need	Reason for Replacement Needed	Requested By	Date

Rx Status Key:

Nurse Ordering:

Date:		Notes: _____
Call M.D. (CMD) ----->	Pharmacy has submitted refill authorization to physician for approval (Rx Advantage, Inc. will request 48-72 hr turn around))	_____

This facsimile transmission is intended for the individual or company to whom it is addressed and may contain information which is privileged, confidential, and prohibited from disclosure or unauthorized use under applicable law. If the recipient of this transmission is not the intended recipient, or the employee or agent responsible for delivering such materials to the intended recipient, you are hereby notified that any use, discussion, or copying of such material is strictly prohibited by the sender. If you have received this transmission in error, please notify us immediately by telephone at the number above and return the material to the sender by mail. Thank you.