# MEDICATION REFILL REQUEST FORM

****Orders must be received <u>2 HOURS</u> 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:

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

Notes:_____
_____
_____
_____
_____



7101 Highway 90, Suite 300 ● Daphne, Alabama 36526
Phone (251) 625-6100 ● Toll Free (877) 770-7923 ● Fax (251) 625-6502 ● Toll Free Fax (866) 478-7909