



## 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                            |                                      |                     |             |
| <b>Patient Name</b> | <b>Medication</b> | <b>Rx #</b>                               | <b>Qty on hand</b>                   | <b>Rx Status</b>    |             |
|                     |                   |   |                                      |                     |             |
|                     |                   |   |                                      |                     |             |
| <b>Patient Name</b> | <b>Medication</b> | <b>Replacement Dose Date/Time of Need</b> | <b>Reason for Replacement Needed</b> | <b>Requested By</b> | <b>Date</b> |
|                     |                   |   |                                      |                     |             |
|                     |                   |   |                                      |                     |             |

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)) | _____        | _____ |
|                        |   | _____        | _____ |
|                        |   | _____        | _____ |

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