



FACILITY: _____

FAX REFILL REQUEST TO (816) 931-0282

Please reorder medications when 5 days remain allowing time to process, order product, or contact physician for refills. If needed sooner than 5 days, specify below.

Example label – available refills circled

* * PHARMACY WILL NOT ACCEPT THIS REORDER REQUEST UNLESS SIGNED AND DATED * *				
Date Ordered By	AFFIX LABEL or specify patient name & medication	When will med run out?	Notes	FOR PHARMACY USE ONLY
	Patient: Med:	Date		Filled
				Ø RF-Contacted Physician
				Insurance Issue: RTS PA
				Out of Stock
	Patient: Med:	Date		Filled
				Ø RF-Contacted Physician
				Insurance Issue: RTS PA
				Out of Stock
	Patient: Med:	Date		Filled
				Ø RF-Contacted Physician
				Insurance Issue: RTS PA
				Out of Stock
	Patient: Med:	Date		Filled
				Ø RF-Contacted Physician
				Insurance Issue: RTS PA
				Out of Stock
	Patient: Med:	Date		Filled
				Ø RF-Contacted Physician
				Insurance Issue: RTS PA
				Out of Stock
	Patient: Med:	Date		Filled
				Ø RF-Contacted Physician
				Insurance Issue: RTS PA
				Out of Stock
	Patient: Med:	Date		Filled
				Ø RF-Contacted Physician
				Insurance Issue: RTS PA
				Out of Stock
	Patient: Med:	Date		Filled
				Ø RF-Contacted Physician
				Insurance Issue: RTS PA
				Out of Stock

Legend: Ø RF = No refills, we have contacted the physician for authorization; **Insurance Issue - RTS** = Refill Too Soon, insurance will not allow refill to be billed; **Insurance Issue - PA** = Prior Authorization required by insurance; we have contacted the physician; **Out of Stock** = Product will be ordered today, anticipated delivery date noted.