

Medication Refills

TIP: Additional pages can be added by going to the Attachments section of this document.
Contact prescriber immediately if a drug is on back order or the pharmacy is unable to fill.

Dispensing Pharmacy	Prescribing Physician	PA Required?	Medication Name	Generic Acceptable?	Dosage	Frequency	Quantity (30/90/120 day supply)	Covered by Insurance?*	Purpose	How is this medication taken?	Preparation Type (pill, capsule, liquid, chewable,etc.)	Comments/ Notes
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> YES <input type="checkbox"/> NO				
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> YES <input type="checkbox"/> NO				

*See medication page for coverage details.