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## PHARMACY ALERT

**USE OF THIS PAGE AS YOUR COVER SHEET IS REQUIRED. FAILURE TO DO SO WILL RESULT IN FURTHER DELAY OF PROCESSING YOUR REQUEST.**

PATIENT:	DATE:	TIME:
ATTN:	FACILITY:	FROM:
<b>MEDICATION / CONFLICT</b>		
<b>REASON(S)</b>		
<input type="radio"/> PRIOR AUTH REQUIRED	<input type="radio"/> MISSING INFORMATION	<input type="radio"/> PAYMENT INFO / CREDIT CARD
<input type="radio"/> REFILL TOO SOON	<input type="radio"/> THERAPEUTIC INTERVENTION	<input type="radio"/> CREDIT HOLD / AWAITING DEPOSIT
<input type="radio"/> NO REFILLS / RX EXPIRED	<input type="radio"/> DRUG OUT OF STOCK	<input type="radio"/> RX FILLED @ ALTERNATE PHARMACY
<input type="radio"/> DUPLICATE THERAPY	<input type="radio"/> INSURANCE DECLINED	<input type="radio"/> OTHER
<b>EXPLANATION</b>		
<b>FACILITY FOLLOW-UP ACTION</b>		
<input type="radio"/> DC Order	<input type="radio"/> New Order:	Date:
<input type="radio"/> New Payment Information (put in comments)	Drug Prescribed:	
<input type="radio"/> Missing Information (put in comments)	Quantity:	
	Refills:	
	MD Signature:	
<b>COMMENTS</b>		