Prescription Request Authorization

Fax:

Date:

Refills RequestedAuthorized: 5

We request refill/renewal authorization on behalf of your patient

DOB:

Phone:

Please fax or call this request to:

Fax:

Patient:

Signature: _____ Date: _____

Doctor:

NPI:

Phone: Fax:

Dispense as Written: ☒

Comments: