

Prescription Request Authorization

Fax:

Date:

Refills Requested Authorized: 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:

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