

Walgreens

Second Prescription Refill Request

1300 N MAIN ST
NEWTON, KS 671141916
Tel: 316-281-9356 Fax: 316-281-9335

Date: 08/26/2015

Time: 3:54 PM

Prescriber Information:

Physician: SYLVIANE KASENDE
Address: 2925 SKYWAY CIR N
IRVING, TX 750383510

Phone: 972-675-7313
Fax: 972-675-7310
DEA #: MK3265522

Patient Information:

Patient: AARON JACKSON
Address: 400 MAPLE RIDGE RD APT 33
HESSTON, KS 670629635

Birthdate: 11/23/1973
Med Record #:
Phone: 620-217-0042

Prescription Information:

Rx Number: 373243-07152
Drug: CLONIDINE 0.2MG TABLETS
Generic For:
Sig: TAKE 1 TABLET BY MOUTH THREE TIMES
DAILY

Requested P/U Time: 08/24/2015 12:51PM
Prescribed Qty: 270
Last Refill: 07/09/2015

Message:☐ Denied _____

☐ If there are **NO** changes to the Rx please
circle TOTAL # of Authorized Refills:

PRN 6 5 4 3 2 1

☐ Authorized as a 90 day supply
PLUS # of additional Refills:

PRN 3 2 1 0

If there **ARE** changes to the Rx please
check box and write in changes.

☐ Drug: _____☐ Directions: _____☐ Refills: _____ ☐ Qty: _____

Authorized by: _____

In accordance with state regulations, a generic will be substituted unless otherwise indicated.

☐ Dispense as Written/Brand Medically Necessary

Please fax back to Walgreens at: 316-281-9335

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