

CEDAR GROVE PHARMACY

1580 Main Street | Willowdale, OR 97333
Phone: (555) 221-3344 | Fax: (555) 221-3345
NPI: 1122334455 | DEA: BC7654321

PRESCRIPTION REFILL REQUEST

Date/Time: 02/10/2026 09:17 AM

URGENT: Patient has 0 refills remaining

TO: Dr. Evelyn Sato, DO — Whispering Pines Family Medicine
FAX: (555) 867-5309

PATIENT INFORMATION

Patient Name: NAKAMURA, KENJI
Date of Birth: 07/11/1969
Phone: (555) 332-7788
Insurance: Blue River Health — ID# BRH-445-9012
Allergies on file: Penicillin, Sulfa

MEDICATION REFILL REQUESTED

| Rx # | Medication | Strength | Directions | Qty | Last Filled |
|----------|---------------|----------|---------------------------|-----|-------------|
| RX-78223 | Lisinopril | 20mg | Take 1 tab PO daily | 90 | 11/12/2025 |
| RX-78224 | Metformin HCl | 500mg | Take 1 tab PO BID w/meals | 180 | 11/12/2025 |
| RX-78225 | Atorvastatin | 40mg | Take 1 tab PO at bedtime | 90 | 11/12/2025 |

PRESCRIBER RESPONSE (please check and fax back):

- APPROVED as requested — Refill authorized for _____ months
 APPROVED with changes (see below)
 DENIED — Patient must schedule appointment before refill
 DENIED — Medication discontinued / changed to: _____

Notes: _____

Prescriber Signature: _____ Date: _____

Please respond within 48 hours. Patient last seen: 10/28/2025.
If no response received, pharmacy will contact patient to schedule office visit.