

REQUEST FOR A REFILL OR NEW PRESCRIPTION

AUTO-FAX ELECTRONICALLY TRANSMITTED:

PRESCRIBER:

Name: MELODYE HARVEY
Address: 7461 EAST DRIVE
MONTGOMERY, AL 00003-6117
Phone: 334-244-3281
Fax: 334-244-3396

From: CVS Pharmacy

Store #: 585
Address: 9505 VAUGHN RD
PIKE ROAD, AL 36064
Phone: 334-277-1153
Fax: 334-277-1855

Patient expects to pick-up prescription: Tomorrow 11 AM**FOR PATIENT:**

Name: ARMSTRONG, JAMES
DOB: 07/17/1979
Address: 160 STONE PARK BLVD APT 2101
PIKE ROAD, AL 36064
Phone: 205-826-7022

FOR ORIGINAL PRESCRIPTION:

CVS Rx# 622782 Date Last Filled: 2/5/2020
Medication: CETIRIZINE HCL 10 MG TABL
Qty. Prescribed: 30
Prescribed Refills: 0
Date Written: 2/5/2020
SIG: TAKE 1 TABLET BY MOUTH EVERY DAY IN THE EVENING

Pharmacy Comments:

PRESCRIBER ACTION REQUIRED:

- ☐ Authorized this time plus _____ additional refills
☐ New Prescription Authorized plus _____ additional refills
☐ Not Authorized

Prescriber Comments:

Prescriber's Name (Printed): _____ Prescriber's DEA # _____
Transmitted by: _____ (KS/TX ONLY) DPS # / Oral Code _____ (TX/HI ONLY)
Prescriber's Signature: _____ Date: _____
Massachusetts Only: Interchange is mandated unless Practitioner writes the words "No Substitution"

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FOR CVS USE ONLY:**REQUEST FOR A REFILL OR NEW PRESCRIPTION**

scribed
3/5/2020
MA