PharMerica®
Senior Living

THIS FILE IS THE ORIGINAL FORM DOCUMENT

Please duplicate the file and delete this page before using.

Refills Only Fax Order Form

PharMerica® Senior Living

Community Name:	
Staff Name:	Order Date:

Please attach fax confirmation to this sheet after faxing to the pharmacy.

Fax To:	Unit:

Refill medications when a 5-days' supply is remaining. • For refills needed within 24 hours: fax, then call pharmacy.

Please call the pharmacy if you need any of these refills before the next scheduled delivery, per the cut-off times on your General Information Poster.

Place Refill Stickers in this Column	Place Refill Stickers in this Column	Place Refill Stickers in this Column

Illegible handwriting may delay service. Please use this form only once per order.
Cycle Communities: Do not use this form to request cycle medications; please use Fax Cover Page.

New Prescription Fax Form

PharMerica® Senior Living

Community Name:	Phone:	Fax:
Address:		
Physician Name:	Phone:	Fax:
Physician Address:		
DEA Number:	NPI Number:	
Physician Medication Verification for:		
Resident:	DOB:	
Pharmacy:	Phone:	Fax:

My signature below authorizes the below medications to be filled for a 30-day supply with 11 refills unless otherwise noted on the orders. This authorization does NOT apply to controlled substances as they must be ordered per DEA regulations.

Medication	Strength	Qty	Directions	Refills	Diagnosis

Physician Signature:	Date:

eMAR Discontinue Error Fax Form

PharMerica® Senior Living

Pharmacy:		From:
Fax:	Unit:	# of Pages:
Phone:		Date:
Resident Name:		Staff Name:

- ☐ Resident Date of Birth:
- ☐ Medication Name:
- ☐ Medication Strength:
- ☐ Medication Directions:
- ☐ Notes (optional):

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