**THIS FILE IS THE ORIGINAL FORM DOCUMENT**

**Please duplicate the file and delete this page before using.**

# Refills Only Fax Order Form

| 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 |
|---|---|---|
| | | |
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**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.**

*CONFIDENTIALITY NOTICE: The information contained in the facsimile is intended only for the use of the individual(s) or entity(s) to which it is addressed and may contain information that is confidential and/or legally privileged under state and federal law. If you are not the intended recipient of this facsimile message or an agent or employee responsible for delivering it to the intended recipient, you are hereby notified that any unauthorized dissemination or copying of the information contained therein is strictly prohibited. If you have received this communication in error, please notify the sender. Do not deliver, distribute, or copy this message. and do not disclose its contents or take action in reliance of the information it contains. Thank you.*

# 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 |
|---|---|---|---|---|
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| Agent of the Prescriber Signature: | Date: |
|---|---|
| Physician Signature: | Date: |

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# eMAR Discontinue Error Fax Form

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

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

**Illegible handwriting may delay service. Please use this form only once per order.**
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