Prescription Status

Patient Name: Date: _____ Rx # _____ Medication Name:	Check boxes that apply:
No refills remain.	
We contacted your prescriber for a new prescription	
Your prescriber requests that you make an office visit for further refills.	
We contacted your prescriber to verify dose, directions, & quantity on your prescription.	
Your prescription was ordered and should be in ___ / ___ / ___	
You should have remaining medication from a previous fill. Date _____ / _____ / _____ Day Supply_____	
Your insurance will not pay for the prescription yet due to a previous fill. Date _____ / _____ / _____ Day Supply_____	
Your directions changed but you should have remaining medication from a previous fill Date _____ / _____ / _____	
Have your directions or dose changed on this medication?	
There is a drug interaction between this and another medication. We have contacted your prescriber for instructions.	
There is a cost saving alternative to your medication.	
Your insurance does not prefer this medication.	
We contacted your prescriber for medication alternative(s) or a P.A.	
Your medication was changed to a less expensive alternative	
Talk to your pharmacist about _____	
Our records show there is a possibility you may be allergic to this medication	

L & S Pharmacy

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