## Prescription Status

<table>
<thead>
<tr>
<th>Patient Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Rx #:</td>
</tr>
<tr>
<td>Medication Name:</td>
</tr>
</tbody>
</table>

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.

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