MANAGED HEALTHCARE pharmacy since 1991

Fax: (866) 367-8702 Phone: (866) 367-8701
P.O. Box 2767 ● Eugene, OR ● 97402

CYCLE MEDICATION REPLACEMENT

Patient Name _____ DOB _____

Facility _____

Medication _____ Rx # _____

The cycle medication listed above needs to be replaced due to the following reason:

- ☐ Medication was dropped and wasted
- ☐ Medication was refused 3 times and wasted
- ☐ Medication was spit out
- ☐ Other (explain) _____

Quantity of replacement medication needed: _____

IF MORE THAN ONE DAYS SUPPLY IS REQUESTED, PHARMACY WILL NEED TO GET APPROVAL FROM THE PRESCRIBER.

_____ _____
Signature of Facility Staff Date

FAXED TO MHP_____
Date and initials

PLEASE COMPLETE AND FAX TO PHARMACY AS SOON AS POSSIBLE