



Fax: (866) 367-8702 Phone: (866) 367-8701  
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## 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**

**PHI HIPAA Compliance Statement**

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