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): _____

Total Quantity of replacement tablets/capsules needed: _____

PLEASE NOTE: Any controlled substance must have an approval from the prescriber before any additional medication can be sent out.

_____ _____

Facility Staff Name (print) Date

FAXED TO MHP: _____

Date and Initials

PLEASE COMPLETE AND FAX TO PHARMACY AS SOON AS POSSIBLE