PSYCHIATRIC / SUBSTANCE ABUSE

Early Refill/ More than 30 day supply Request Form

Fax requests to: 972-578-6619 Attn: Pharmacy Coordinator

Consumer's Name: _____
First Middle Initial Last

Member's LifePath Systems ID Number: _____ Date of Birth: ____ / _____/ _____

Physician (Full Name): _____ Contact Person: _____

Physician's Address: _____

Phone Number: _____ Fax Number: _____

Medication Requested: _____ Medication Strength: _____

Tabs per day/ Frequency _____ Medication Allergies:_____

Diagnosis treating with this Medication: _____

Is the member currently stable on this medication? ____Yes ___No ; For how long: _____

Request for CoPay Waiver: _____Yes _____No

Rationale for the request: _____
_____
_____
_____
_____
_____
_____

Physician's Signature: _____ Date: ____/ ____/ _____