



Physician Medication Therapy Change Form

Phone: 770-507-1559

Fax: 770-692-8247

Today's Date: _____

Patient Name: _____

DOB: _____

Facility Name: _____

Patient's CURRENT Cycle Start Date: _____

Patient's NEXT Cycle Date: _____

Dear Physician,

Our mutual patient resides in a facility where their medications are packaged on a monthly cycle. We send these medications directly to the facility automatically where they assist the patient with the administration. To help contain costs to the family, prevent call-backs to your office and to expedite service to the facility, please answer the following brief questions.

Best Regards,

Moye's LTC Pharmacy

1. Is the medication(s) you are writing for today: NEW CHANGE D/C (circle one)
2. Can this new medication(s) or change(s) begin on the NEXT cycle date listed above?
YES NO (circle one) If no, specify start date: _____

MED CHANGES MAY TAKE UP TO 72 HOURS

3. If medication is a chronic medication, please indicate how long we may refill this prescription before you wish to be contacted for refills:

6 Months 1 Year (circle one) or specify date: _____

Authorized Signature: _____

****Instructions for Facility– please fax this along with prescriptions to our pharmacy****