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**PRESCRIPTION REFILL FAX FORM** to be faxed by the practice only  
 ALL AREAS MUST BE COMPLETED FOR PROPER PROCESSING

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_.

Prescribing Doctor Name as it appears on License \_\_\_\_\_ Signature \_\_\_\_\_

CLINIC Name \_\_\_\_\_ Phone # \_\_\_\_\_

<u>RX Number</u>	<u>Patient First &amp; Last Name</u>	<u>Drug</u>	<u>Strength</u>	<u>Form</u>	<u>Qty</u>

**CONFIDENTIALITY NOTICE**

The attached document contains information that may be confidential and is intended only for use by the addressees. If you have received this facsimile in error, please notify us immediately by telephone at 833-633-4838.