Employee Pharmacy
Refill Transfer Request

Patient Name_____

Pharmacy Name_____

Pharmacy Phone Number_____

Medication(s) to be Transferred	Rx Number (if available)	Prescriber's Name
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please allow 1 to 2 business days for transfers

Please Note:

- New York State does not allow the transfer of controlled substances or controlled devices.
- Only one refill may be transferred at a time.
- Medicaid does not allow the transfer of prescriptions.

If we are unable to transfer your refill(s), would you like to be contacted?
Contact phone number_____

May we contact your doctor for a new prescription?
_____ **Yes** _____ **No**

****WHEN COMPLETE, you may either bring this form to the secure drop box located outside the new pharmacy, or fax it to 276-2600 ****