Employee Pharmacy
Refill Transfer Request

Patient Name__________________________________________________________

Pharmacy Name_______________________________________________________

Pharmacy Phone Number_______________________________________________

Medication(s) to be Transferred | Rx Number (if available) | Prescriber’s Name
-------------------------------------------------------------------------
________________________________ | ____________ | __________________
________________________________ | ____________ | __________________
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***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**