Pharmacy Prescription Transfer Template

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), this informs you of this document's purpose and how it will be used.
AUTHORITY: 10 U.S.C 136; 10 U.S.C. 1074f; DoD Directives 1404.10, 5101.1, 5136.01, and 6490.02E; and DoD Instruction 6025.19. **PURPOSE:** To obtain information in order to transfer prescriptions to the Military Treatment Facility at the beneficiary's request. **DISCLOSURE:** Voluntary.

SECTION A: COMPLETED BY (SELECT ONE)*

☐ **Patient** ☐ **Patient's Legal Guardian** _____

DATE*:	

Fields marked with an asterisk (*) are required. Please include as much information as possible. When finished, hand or fax this authorization to your pharmacy to begin the prescription transfer process. If you have bottles, packages, or labels from the prescriptions you would like transferred, providing them to your pharmacy may expedite the processing of your request.

PATIENT INFORMATION		
NAME (Last, First, MI)*:	DOB (MM/DD/YYYY)*:	DOD ID#:
Phone #*:	Address (Street, City, State, and ZIP Code):	
Allergies *(please list all allergies)*:		

TRANSFERRING FROM INFORMATION	
Pharmacy Name*:	Pharmacy Phone #*: *(Check Rx label)*
Address (Street, City, State, Zip Code):	Fax:

PRESCRIPTION INFORMATION (List all of the medications you would like transferred; additional medications on reverse side)	
Medication Name(s)*:	Prescription #(s):
1.	1.
2.	2.
3.	3.

SECTION B: TO BE COMPLETED BY THE PHARMACY RECEIVING THE PRESCRIPTION(S)

For pharmacy personnel use only. All fields are required for each prescription requested for transfer.

PHARMACY INFORMATION	
Name of Receiving Pharmacist:	Name of Transferring From Pharmacist:
Receiving Pharmacy DEA (Required for controlled substances): AU2966767	Transferring From Pharmacy DEA (Required for controlled substances):
Receiving Pharmacy (Name, Address, City, State, ZIP Code, Phone #, and Fax #): Little Rock AFB; 1090 Arnold Drive LRAFB AR 72099; (phone: 501-987-7446) (fax: 501-987-8786)	

DRUG INFORMATION (for #1 above)		**DRUG INFORMATION (for #2 above)**		**DRUG INFORMATION (for #3 above)**	
Drug Name:		Drug Name:		Drug Name:	
Strength:	Quantity:	Strength:	Quantity:	Strength:	Quantity:
Sig:		Sig:		Sig:	
Refills Remaining:	Date Written:	Refills Remaining:	Date Written:	Refills Remaining:	Date Written:
Orig. Fill Date:	Last Fill Date:	Orig. Fill Date:	Last Fill Date:	Orig. Fill Date:	Last Fill Date:
Provider:		Provider:		Provider:	
DEA:	NPI:	DEA:	NPI:	DEA:	NPI:

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ADDITIONAL PRESCRIPTION INFORMATION (If necessary)	
Medication Name(s)*:	Prescription #(s):
4.	4.
5.	5.
6.	6.

DRUG INFORMATION (for #4 above)		**DRUG INFORMATION (for #5 above)**		**DRUG INFORMATION (for #6 above)**	
Drug Name:		Drug Name:		Drug Name:	
Strength:	Quantity:	Strength:	Quantity:	Strength:	Quantity:
Sig:		Sig:		Sig:	
Refills Remaining:	Date Written:	Refills Remaining:	Date Written:	Refills Remaining:	Date Written:
Orig. Fill Date:	Last Fill Date:	Orig. Fill Date:	Last Fill Date:	Orig. Fill Date:	Last Fill Date:
Provider:		Provider:		Provider:	
DEA:	NPI:	DEA:	NPI:	DEA:	NPI: