PRESCRIPTION RENEWAL REQUEST

Date: 02/20/2008

Company: AmMed HomeCare Pharmacy

Return Fax: +1 (877) 454-2722

Y436535

000001

Internal use only

Patient Information

Patient Name: PATIENT,DEFAULT

Patient Address: 123567 MAIN STREET DOYLESTOWN PA USA

Patient Phone: +1 (123) 123-4567

Change Information

Address: ______________________________

City: ______________ State: __________ Zipcode: ________

Phone: ______________________________

Method of Payment

(Please circle)

Credit Card: Visa Mastercard AmEx Discover

Credit Card #: ______________________________

Expiration Date: ______________________________

I hereby authorize that the information provided is correct.

Signature: ______________________________ Date: __________

*Only doctors are permitted to fax renewal prescriptions. Schedule II medications cannot be faxed.

*Your doctor must sign each renewal prescription. To reorder, mail or have your doctor fax this form to our pharmacy.

Prescription Renewal Information

000001

Patient Name: PATIENT,DEFAULT

Patient Address: 123567 MAIN STREET DOYLESTOWN PA USA

Written Product: OXCARBAZEPINE TAB 150 MG

Quantity: 30

Directions: TAKE 1 TABLET BY MOUTH EVERY DAY

Refills: __________ Doctor Name: DR. DOCTOR TEST

MD Signature: ______________________________ Date: __________

MD Address: ______________________________

MD Phone: ______________ DEA#: ______________

*NPI Number: ______________________________

*M.D. must intial any changes.

*Unless clearly indicated, a generic product will be substitued when legally permissible.