

CVS/pharmacy**Transferred Prescription**

Date/Time: _____

Name: _____ Phone: _____

DOB: _____ Allergies: _____ ☐ Infant/Pediatric

Address: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____ DEA: _____

Orig. Rx #: _____ Date Written: _____ Date Orig. Filled: _____

Last Date Filled: _____ Orig. # of Refills: _____

Transferor R.Ph. Name: _____

Rx	Test for
01315	U
Medication Purpose: _____ Refills: _____	
Read Back: ☐ DOB ☐ Drug Name ☐ Strength ☐ Directions	

DISPENSE AS WRITTEN/BRAND MEDICALLY NECESSARY/
DO NOT SUBSTITUTE/NO SUBSTITUTION/DAW

Dr. _____

MAY SUBSTITUTE/PRODUCT SELECTION PERMITTED/
SUBSTITUTION PERMISSIBLE/INTERCHANGE MANDATED
UNLESS PRACTITIONER WRITES THE WORDS NO SUBSTITUTION.

Dr. _____

Dr. Phone: _____ DEA or State license #: _____

Address: _____