CVS/pharmacy®

Telephone Order Prescription Pad

Date/Time: _____

Name: _____

DOB: _____ ❑ Infant/Pediatric

Phone: _____

Address: _____

Allergies: _____

Rx

Medication Purpose: _____ Refills: _____

Read Back: ❑ DOB ❑ Drug Name ❑ Strength ❑ Directions

Interchange is mandated unless the practitioner writes the words "No Substitution" in this space

Phoned in by: _____ Voice Mail ❑

Prescriber: _____

Phone: _____

DEA or State license number: _____

Address: _____

Item # 182779 Rev. 04/19 PCN_00005

CVS Staff Initials: _____