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: _____

℞

Medication Purpose: _____ Refills: _____

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

'DISPENSE AS WRITTEN'/BRAND MEDICALLY NECESSARY/ DO NOT SUBSTITUTE/NO SUBSTITUTION/DAW	'MAY SUBSTITUTE'/PRODUCT SELECTION PERMITTED/ SUBSTITUTION PERMISSIBLE/INTERCHANGE MANDATED UNLESS PRACTITIONER WRITES THE WORDS NO SUBSTITUTION.
Dr.	Dr.

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

Address: _____

CVS Staff Initials: _____