MANAGED HEALTHCARE pharmacy
A Guardian Pharmacy®

PHONE: (866) 367-8701 FAX: (866) 367-8702

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CYCLE MEDICATION REPLACEMENT

RESIDENT NAME: _____ DOB: _____

FACILITY NAME: _____

MEDICATION: _____ RX#: _____

The cycle medication listed above needs to be replaced due to the following reason:

- ☐ Medication was dropped and wasted
- ☐ Medication was refused 3 times and wasted
- ☐ Medication was spit out
- ☐ Other (explain): _____

Total Quantity of replacement tablets/capsules needed: _____

PLEASE NOTE: Any Controlled substance must have an approval from the prescriber before any additional medication can be sent out.

_____ _____

Facility Representative (print) Date Submitted