
FlexCycle Fill Pause Request

Use this form when a patient has enough medication on hand and you would like MHP FlexCycle filling paused until a specified date. Complete one form per medication.

Fax completed form to 866-367-8702

Patient and Medication

Facility: _____

Patient name: _____

Date of birth: _____ Request date: _____

Medication name and strength: _____

Prescription number: _____

Provide the medication name and strength and/or prescription number.

Supply on hand

Amount on hand: _____ **Unit:** _____

Examples of units: tablets, capsules, mL, or patches. Include all available packages.

Date counted: _____ Time counted: _____ ☒ AM ☐ PM

This supply will cover the patient for _____ days from the date counted.

Requested Fill Pause

Please pause MHP FlexCycle filling for the medication listed above.

Requested date to resume filling: _____

This request applies only to pharmacy filling. Continue administering the medication according to the current order. Notify the pharmacy if the supply or medication needs change before the requested resume date.

Completed by

Name and title: _____

Contact phone: _____

Comments: _____

Fax back to 866-367-8702

- PHI HIPAA Compliance Statement -

This communication may contain confidential Protected Health Information. This information including any attachment is intended only for the use of the individual or entity to which it is addressed. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to securely store or destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is **STRICTLY PROHIBITED** by federal law. **If you have received this information in error, please notify the sender immediately and destroy this transmission.**