University Health System

Rx & GO PROGRAM
Prescription MAIL OUT Request Form

Mail Out Processed by DOWNTOWN PHARMACY only.

Phone (210) 358-9654 or (210) 358-9657 or Toll Free (800) 760-9654
Fax (210) 358-9650

Mail to Downtown Pharmacy (UHC-DT Pharmacy MS 36-2, 903 W. Martin Street, 78207)

UFCP Patient's Name: _____ D.O.B. _____

Daytime Phone #: _____ Home Phone #: _____

Medical Record #:_____

Insurance Card Member #:_____(Copy of insurance card may be attached)

PLEASE CHECK ONE: ☐ **Employee** ☐ **Retiree/Cobra** ☐ **Dependent**

ALLERGIES (for person named on prescription): ☐ None known ☐ Yes (please list):

_____

☐ **Please check box if Provider has faxed or will fax Prescriptions**

Please carefully print mail out information below:

Name: Address: City, State & Zip code:	**(PHARMACY USE ONLY)**

GENERAL INFORMATION and REQUIREMENTS:

- **Please allow at least 7 business days for processing and mailing. If you have less than 7 days supply remaining, consider filling a 30 day supply for pick up.**
- **Prescriptions must be written by a UT - Medicine/CMA/UHS Prescriber.**
- **This form MUST be completed each time prescriptions are being requested for mail-out.**
- **Controlled Substances and prescriptions that require special handling cannot be mailed.**

If a less expensive, generically equivalent drug is available for the brand prescribed, the patient or the patient's agent may choose between the generically equivalent drug and the brand prescribed:

- **If no choice is made, the least expensive product will be used. Generic ☐ or Brand ☐**

FOR REFILL PRESCRIPTIONS (entire form must be completed <u>each time</u> a refill is requested):

- **Check the prescription label to verify you have refills remaining and that the prescription is not expired.**
- ***If your doctor has changed the instructions for taking a medication, please notify pharmacy and/or submit a new prescription. This will help prevent interruption of therapy if your dose has increased.***
- **Please have your doctor give you a new prescription if refills or prescription have expired.**
- **Refills can be ordered up to 2 weeks early.**

Complete All Three Columns of Information for Refills			**Also Complete these Two Columns to Transfer Prescriptions from a Retail Pharmacy (Prescriber must be UPG, CMA or UHS)**	
Prescription #	**Drug Name & Strength**	**Days Supply/Qty**	**Pharmacy Name**	**Pharmacy Phone #**

My signature below indicates that I have read and reviewed the information submitted and the information is accurate. I also understand that if my address changes for prescription mail out, it is my responsibility to submit my changes to the Rx & Go Program

Signature_____**Date:**_____

CONSUMER INFORMATION
Complaints

Complaints against the practice of pharmacy may be filed with the:
Texas State Board of Pharmacy
333 Guadalupe, Suite 3-600
Austin, TX 78701

(512) 305-8000
www.tsbp.state.tx.us

To receive a complaint form call:
(800) 821-3205 or (800) 305-8080 (in Austin)
(recorded information only)

INFORMACIÓN PARA EL CLIENTE
Demandas

Se mandan las demandas contra la práctica de la farmacia a:
Texas State Board of Pharmacy
333 Guadalupe, Suite 3-600
Austin, TX 78701

(512) 305-8000
www.tsbp.state.tx.us

Para un formulario de demanda llame:
(800) 821-3205 o (800) 305-8080 (en Austin)
(para información grabada solamente)

Written information about this prescription has been provided for you. Please read this information before you take the medication. If you have any questions concerning this prescription, a pharmacist is available during normal business hours to answer these questions at (210) 358-9654 or (800) 760-9654.

Informacion escrita sobre esta prescripcion a sido proveida para usted. Por favor lea esta informacion antes de tomar el medicamento. Si tiene preguntas concerniendo su prescripcion, un farmaceutico esta disponible durante horas normales de operacion para contestar estas preguntas si llama al (210) 358-9654 o (800) 760-9654.