PRESCRIPTION REFILL POLICY

Our goal is to assist patients with prescription requests in an efficient and timely manner. Parkview Internal Medicine participates with electronic prescribing directly to your mail order or local pharmacy. **Due to the volume of prescription requests, we have created the following guidelines and ask you to please follow them:**

1. It is the patient's responsibility to notify the office in a timely manner when refills are necessary. Call your pharmacy first, Approval may take up to **three (3) business days**, so do not wait to call. If you have a mail order pharmacy, please contact us **fourteen (14) days** before your medication is due to runs out.
2. Refills will only be addressed during normal business hours (**Monday-Friday 8am-4pm**) Please call our office at **623-544-1700, opt 3** & leave all information including: Name, Strength, Dosage & preferred pharmacy. No meds will be refilled on Saturday, Sunday, or Holidays.
3. Refills require close monitoring by your provider to ensure safety & effectiveness. Your Provider will prescribe the appropriate number of refills to last until your scheduled appointment. Generally, when you are down to zero refills, it is time to schedule an appointment.
4. Maintenance meds such as Blood Pressure, Diabetes, Cholesterol or Thyroid will only be approved if the patient has an appointment within 3-6 months as **decided by the doctor**.
5. Controlled Substances such as ADD/ADHD, Antianxiety, and sleep meds will require a **mandatory visit every three (3) months** for med management.
6. Antibiotics or New medications will require an appointment. They are not prescribed over the phone because it generally requires an office visit.
7. Some medications require prior authorizations. It is your responsibility to contact your insurance to see if they cover any alternatives or want you to try something prior to refilling that medication.
8. If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please call our office to schedule an appointment.

We ask that you please sign below to agree that you will follow the Refill Policy.

Patient signature: ________________________________ **Date:** ________