Prescription Transfer Form

Patient Name	Daytime Phone Number
Member id RPZ _____	Is it ok to leave a ____Yes ____ No detailed Mes-
Current Pharmacy Name	Current Pharmacy Phone Number

1	Prescription Number	Medication Name	Strength _____
	Prescriber	Prescriber Phone Number	Supply: ____30 ____ 60 ____90 days
2	Prescription Number	Medication Name	Strength _____
	Prescriber	Prescriber Phone Number	Supply: ____30 ____ 60 ____90 days
3	Prescription Number	Medication Name	Strength _____
	Prescriber	Prescriber Phone Number	Supply: ____30 ____ 60 ____90 days
4	Prescription Number	Medication Name	Strength _____
	Prescriber	Prescriber Phone Number	Supply: ____30 ____ 60 ____90 days
5	Prescription Number	Medication Name	Strength _____
	Prescriber	Prescriber Phone Number	Supply: ____30 ____ 60 ____90 days

Fax this form to Legacy Pharmacy at 318-445-2982 or mail to:

Legacy Pharmacy
1201 N. Bolton Ave, Suite E
Alexandria, LA 71301