B, C or D Refill Request Form

Requesting Agency: ____

Requesting Physician: ____

Consumer Name: ____

Consumer DOB: ____

How many times has this consumer used a B C or D prescription? _________

Medication	Dosage	Number	B C or D

Please briefly explain why this consumer would need refills:

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Approved ____ Denied ____ Signed: __________________________________

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Please remit to Cassandra May at (336) 513-4203.