UPSTATE
OUTPATIENT PHARMACY

# Medication Adherence Prepackaging Program
# COMPLIANCE PACKAGING REQUEST FORM

To submit form:
Email to: pharmacymapp@upstate.edu

ATTN: _____ Today's Date:

| | |
|---|---|
| Patient's Name | |
| Patient's MRN | |
| Patient's DOB: | |
| Patient's Address: | |

**Request: Pre-pack** with mail delivery? Yes ☐ No ☐ **Please have medications ready by**:
**Day supply requested to be pre-packed?** 28 days ☐ 56 days ☐ 84 days ☐ Other ☐
**Does patient need Medicaid copayment deferred?** Yes ☐ No ☐

| Medication Name & Strength | Directions | AM | Noon | PM | Bed | Prescriber | Comments |
|---|---|---|---|---|---|---|---|
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Transfer needed for other medications (PRN, injectable, topical, inhaled) Yes ☐No ☐
List other medications needed for transfer from outside pharmacy:
Outside Pharmacy information for transfer:
Pertinent information about the patient:

Name of person completing this form:

For questions regarding this form, please contact us:
**email:** pharmacymapp@upstate.edu
**phone:** 315-464-8875

Updated: 5/2/23, cmf