Please Fax Reversals on This Form To: 1-877-309-5062

PHARMACY NAME_____

*NABP# **(REQUIRED)** _____

***NPI# (REQUIRED)**_____

RX NUMBER	FILL DATE	PLAN

*** All fields must be filled in or request will be faxed back**

SENT BY:_____

Check here if return call required _____

Phone #: _____

E-Mail Address:_____

PLAN: Medicaid, ADAP, DEL, General Asst., TB, Tobacco, MEPARTD/WRAP