LAHC PHARMACY SERVICES

COVID-19 Prescription Drop-Off Form

(One Form per Patient)

Date_____ Time_____ Pick Up time _____ Submitted By Initials _____

☐ ERX ☐ LYSTER ☐ PAPER RX Number of scripts _____

- **Prescriptions/drop off forms are accepted 0730-1530, Monday through Friday**
- **Prescriptions dropped off at 1000 Thursday may be picked up after 1000 Friday**
- **Prescriptions dropped off at 1000 Friday may be picked up after 1000 Monday**
- **Drive thru pick up times are 0730-1615, Monday through Friday**

Full Name of Patient:_____

Patient's Date of Birth: _____ Sponsor's Last Four:_____

Cell Phone Number:_____ Cell Phone Carrier: _____

Is patient pregnant or breastfeeding? _____

Does patient have any allergies to any medications? _____ If yes, please list medications:_____

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*In the event that it is necessary to contact your provider for any additional information or clarification, the turnaround time may be delayed as we cannot predict when an office will return our call.

	Drug/Strength		**Drug/Strength**
1.	_____	**9.**	_____
2.	_____	**10.**	_____
3.	_____	**11.**	_____
4.	_____	**12.**	_____
5.	_____	**13.**	_____
6.	_____	**14.**	_____
7.	_____	**15.**	_____
8.	_____	**16.**	_____