ALAMO MENTAL HEALTH GROUP
PRESCRIPTION REFILL POLICIES

Prescriptions are not usually refilled outside of scheduled appointments. Our doctors typically write prescriptions in quantities to last until the next scheduled appointment. It is your responsibility to make sure an appointment is scheduled in time to avoid a lapse in your medication. If there is a need for a refill to be called in between scheduled appointments, charges will be applied. Refill requests need to be called in by **your pharmacy**. A minimum of **5-BUSINESS-days** is required for the prescription to be approved. No prescriptions are approved on Fridays past the noon hour.

Insurance companies will often request prior approval for some medications. Certain medications require prior authorization (PA) or a medical exception for coverage. If this step is required, your doctor will have to request and receive approval from your insurance company before the medication will be covered under your insurance plan. This often results in a delay in obtaining the prescription. Please expect a **MINIMUM delay of three to five BUSINESS days**. Please be aware you can still have the pharmacy fill your prescription, but, it will not be covered by your insurance. Your prescription is still valid and you can pay for the medication out of pocket. Prior approvals may be minimized by bringing in your insurance co.'s drug lists or formulary to your scheduled appointment. If a medication is denied by your insurance, needs prior approval, or you find that a medication is too costly, you may need to schedule a follow-up visit with your provider to discuss other medication options.

Some insurance companies require your doctor to write "90-day prescriptions" once a medication is considered long term and is considered a "maintenance drug". If this happens, you will need to have your pharmacy send in a request. Please do not call our office. We will only respond to the request from a pharmacy.

There is a handling charge of **$20.00** for refills outside of scheduled appointments. Any prescription refills without a 5-day notice or any emergency refills will have a **$15.00** (for triplicate medications) or **$25.00** (for non-triplicate medications) charge applied. If a prescription is lost, there will also be a **$25.00** charge and the patient will be required to fill out the lost prescription form before the medication can be refilled. These charges are not billed to your insurance and are the patient's responsibility. Failure to keep regular office visits may result in denial of medication refills.

The State of Texas monitors "Triplicate medications" (such as Ritalin, Adderall, Concerta, Vyvanse, Dexedrine, & Focalin). Thus, **IF** a refill request is approved by your doctor, we must as that you adhere to the following guidelines:

1. You must call the doctor's office each month in order to receive your next refill. When requesting a Triplicate prescription, please provide – the patients full name, age, date of birth, address, and a telephone number where you can be contacted when the prescription is ready to be picked up.

2. Allow **5 days** for the doctor to pull the chart and verify the medication as we have numerous requests for these prescriptions each week. There will be a **$15.00** handling charge for refills outside of scheduled appointments. You may also have triplicate prescriptions mailed to you. They will be sent via certified mail, which may cost you **$3.00**.

3. You will be contacted when your prescription is ready. State law requires that it must be filled within 21 days from the date that is written on the prescription. If it expires, the outdated prescription must be returned to the office, and you may be charged a **$15.00** rewrite fee. If a prescription is lost, there will also be a **$25.00** charge and the patient will be required to fill out the lost prescription form before the medication can be refilled.

Finally, we would like to be sure we have the correct pharmacy information in our computer system. Please complete the information below and sign to show you have read and understand the above information.

PATIENT NAME:_____ DATE OF BIRTH:_____

PATIENT/GUADIAN SIGNATURE:_____ DATE:_____

NAME OF PHARMACY: _____

PHONE NUMBER OF PHARMACY:_____

ZIP CODE OF PHARMACY:_____