Maryland Pharmacy Program - Preferred Drug Program
Medication Change Fax Form

AUTHORIZED PRESCRIBER:
(Physician, dentist, PA, nurse practitioner, podiatrist)

Name: _____
First Last

RECIPIENT:

Name:_____
First Last

Date of Birth: __ __/__ __/__ __ __ __

The above beneficiary has a prescription order from you for the following State of Maryland non-preferred medication.

Current Non-Preferred or Tier 2 Medication Order

Drug Name	Strength	Form	Quantity
Sig:			**Refills remaining:** _____

Please review this order and notify this pharmacy if a change can be made to a Preferred or a Tier 1 medication.

Pharmacy Name: _____-

Pharmacy Telephone: (__ __ __) - _ __ __ - __ __ __ __

Pharmacy Fax: (__ __ __) - __ __ __ - __ __ __ __

Complete Preferred Drug List available at www.providersynergies.com/services/documents/MDM_PDL.pdf

Preferred or Tier 1 Medication: I authorize change to the following Preferred or Tier 1 medication.

Drug Name	Strength	Form	Quantity

Authorized Prescriber Signature: _____

DEA # _____ Telephone (__ __ __) - __ __ __ - __ __ __ __

Date: _____
Form revised 02/01/2008