



Good Value Pharmacy

Patient Adherence and Competency of Therapy (PACT) Referral Form

Phone: 262-925-0201 Fax: 262-925-8373

Please fax this form to the number above and we'll set the patient up on our compliance packaging and home delivery program. We will complete a comprehensive medication review and coordinate with the patient and their doctors to ensure accuracy of the medication regimen. **If available, please fax current med list along with this form**

Patient's Name _____ Date of Birth _____

Address _____ City _____ Zip _____

Phone Number _____ Male Female

Referral Source (you) _____ Referral Source Phone _____

Optional Fields: (we can obtain this information from the patient if you do not complete)

Primary Doctor _____ Specialists _____

Current Pharmacy _____ Current Pharmacy Phone _____

Drug Allergies _____

Last 4 of SSN _____ Insurance: Medicare Medicaid Commercial

BIN# _____ PCN: _____ RxGroup: _____ ID: _____

Caregiver Name _____ Caregiver Phone _____

Select One(for as-needed meds): Easy Open Caps -or- Childproof Caps

-----Internal Use Only-----

- ___ Confirm start date
___ Verify all scheduled maintenance meds billed
___ Add patient to Google calendar (30 days repeating)
___ Add patient to hanging calendar
___ Add patient to new Pacmed list (next to RPH computer)
___ Verify if date repeats more than once on hanging calendar
___ Verify patient is written on newly printed calendar
___ Print delivery log
___ Add notes to delivery log
___ Print bulks labels and write orange slips
___ Give bulk labels to filling tech (write 'w/ cycle' on labels)
___ Reconcile receipts and copays on delivery log
___ Send over to Pacmed machine