WESTERN ALLERGY REFILL REQUEST 2021

Refill Request (Signature Verification) for Patient

FULL NAME:_____
(Please Print)

RX# ☐

☐
Physician Signature

Bill To & Contact Information:

Name:
Address:
Phone #:
Email:

Ship To:

Name:
Address:
Phone #:
Email:

Please Confirm ☐

Fax Completed Form To: 1-877-337-1935

Production commences upon approval. Delivery is estimated 2 weeks after prescription placement date. A shipping tracking number will be forwarded when the compound leaves the lab.

Western Allergy
TEL 866-335-5294
FAX 877-337-1935
EMAIL info@westernallergy.com