Automatic Refill Program Withdrawal Form

Please use one form per prescription.

I understand that by completing and signing this form, I am requesting withdrawal from the Automatic Refill (AR) Program with Pacific Compounding Pharmacy and Consultations (PCPC). I am aware that I need to send this form at least seven days prior to my next anticipated refill date and I will receive written confirmation from PCPC that my request has been honored before withdrawal from the AR Program is complete.
I understand that if I want this prescription to be filled through the Pacific Compounding AR Program in the future, I will have to sign a new AR PRogram Enrollment Form.

RX# _____ **Medication** _____

Patient Name: _____ DOB: _____
Last, First, MI MM/DD/YYYY

Signature: _____ **Date**: _____

Print Name: _____

Note: Pacific Compounding Pharmacy staff will send you confirmation of this request within seven days of receipt of your AR Program Withdrawal Form. Once this prescription has been formally removed from the AR Program, you should not receive any additional charges.
If you feel that you have been charged after the confirmation date of your withdrawal, please contact us as soon as possible so that we can resolve the issue immediately. We have no intention of charging you once you have elected to withdraw from the AR Program.

Return this form in person, by mail (1889 W March Ln, Stockton, CA 95207), or by fax 209-474-7168.

PCPC Use Only:
Date Received: _____ By:_____ Confirmation/Effective date: _____ By _____