



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 auto-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# _____ to withdraw from the AR Program.

Patient Name: _____
Last, First, MI

DOB: _____
MM/DD/YYYY

Signature: _____

Date: _____

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 (312 Lincoln Center, Stockton, CA 95207), or by fax 209-474-7168.

PCPC Use Only:

Date Received: _____ By: _____ Confirmation sent date: _____ By _____