Taras W. Didenko, MD, PC & Associates
1827 Walden Office Square, Suite 510
Schaumburg, Illinois 60173
(847) 496-4525 (v) | (837) 660-2958 (f)

Prescription and Refill Policy

To give the highest level of care to all our patients, we must all follow a well-defined, fair prescription and refill policy. If you have any comments or questions, please speak with our medical assistant.

1. Call your pharmacy and ask them to fax your medication request to (87) 660-2958 or electronically transmit your medication request to our office.
2. Leave your contact information on the medical assistant's voicemail in case there are any questions regarding the medication fill or refill. Additionally, we will only fill your medications until your next appointment, so please follow your doctor's treatment plan.
3. Medication refill requests that we receive by 2 PM we will process by close of business on that day. Requests we receive after 2 PM we will handle on the next business day. Please take into account recognized holidays.
4. We will assess a $45 service charge for any refill granted for your convenience because you missed or canceled an appointment. We expect you to make and keep appointments before your prescriptions run out. The policy is to allow for medication adjustments and review of symptom relief.
5. We will assess a $45 service charge for any prescription or refill written to replace one that was lost or stolen. You must present a police report describing the circumstances surrounding the loss of your medication or prescription.
6. You must bring prescriptions for SCHEDULE II Controlled Substances to your pharmacy and filled within ninety (90) days. These include the following:

    6.1. Amphetamine or Amphetamine Salts (ADDERALL)
    6.2. Methylphenidate (RITALIN, CONCERTA, METHYLIN, METADATE)
    6.3. Dextroamphetamine (DEXEDRINE)
    6.4. Dexmethylphenidate (FOCALIN)
    6.5. Buprenorphine (SUBUTEX, SUBOXONE)

7. We will assess a $45 service charge for any SCHEDULE II prescriptions you do not fill with ninety (90) days, and we must reissue a new prescription.
8. Please watch your medications and call us 5-7 days before your last dose to avoid any delay or lapse in your treatment.

My signature indicates my understanding and acknowledgment of the above information & policies.

Print Name *(First MI Last)*: _____

Signature: _____

Today's Date *(mm/dd/yyyy)*: _____