



# Coquille Indian Tribe Pharmacy

630 Miluk Drive  
Coos Bay, OR 97420  
Phone: (541) 435-7039

## Automatic Refill Program Agreement

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please list the name and strength of medication(s) you would like to set up for automatic refill:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- "I consent to receive automatic refill of my maintenance medications. Maintenance medications are those medications taken on a continuous basis for chronic conditions consistent with my current medication therapy plan.
- I understand that I must request automatic refill from a CIT Pharmacy Team member for each medication I would like included in the Auto-Refill Program.
- Controlled substances are not eligible for automatic refill.
- I understand I may request to be disenrolled from the Auto-Refill Program at any time by contacting the CIT Pharmacy.
- Any medication that is returned to stock or delivery is refused will be removed from the Auto-Refill Program.
- I understand that if my prescription insurance restricts the auto-refill of prescription medications, I will not be enrolled in the Auto-Refill program (for example, Oregon Medicaid)."

\_\_\_\_\_  
Patient/Patient 's Agent Signature

\_\_\_\_\_  
Date