PROACT PHARMACY SERVICES

Register now to receive

Automatic Refills!

Pharmacy Benefit Dimensions®

At ProAct Pharmacy Services, we want to make your life easier! With our Automatic Refill Program, you never have to worry about requesting a refill again. We can schedule your prescriptions to be automatically filled and shipped right to your door!

How does it work?
You select which medications you wish to enroll, we take care of the rest! Your prescription will be automatically refilled and shipped to you prior to running out of your current supply.

Getting started!
Getting started is easy! You can enroll in our Automatic Refill program through any of the following:

1. Register Online at www.proactpharmacyservices.com/pbd/autofill.html
2. Email – MailOrder@ProActPharmacyServices.com
3. Phone – 1-888-425-3301
4. Or return this form via Mail to - ProAct Pharmacy Services
   1226 US Highway, Route 11
   Gouverneur, NY 13642

Simply let us know which medications you would like to enroll, and we will take care of the rest.

What if your prescription changes?
Please notify us of any changes to any enrolled medications such as change in dose, directions, or discontinuation of a product to ensure obsolete orders are not automatically filled and shipped, as pharmacy regulations prohibit the return of a delivered prescription medication.

ProAct Pharmacy Services' Automatic Refill program is only for maintenance medications that you will be taking long term. The Automatic Refill program is not intended for medications requiring frequent lab testing, controlled substances, or topical applications. If you have a question on which of your medications can be enrolled, please contact us at: 1-888-425-3301

Name _____ **Date of Birth** _____

Address _____ **Phone (Day)** (____)___ - _____

_____ **Email** _____

Prescriptions to Enroll _____

_____

By completing and submitting this form, I understand that I am requesting enrollment in ProAct Pharmacy Services' Automatic Refill Program. I agree to notify ProAct Pharmacy Services of any changes that may occur to any prescription medications enrolled in this program. I understand that medications in ProAct Pharmacy Services' Automatic refill program will be shipped to my primary address on file unless otherwise indicated.

Patient's Signature _____ **Date** _____

ProAct Pharmacy Services reserves the right to discontinue this service
Visit us on the Web at www.proactpharmacyservices.com/pbd