

**Medication Therapy
Management**

Kemper Drug

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To: _____ Date _____
From: _____ # of pages _____

Urgent (Today) Not Urgent At Next Visit

Your Patient: _____ DOB _____

Medication Therapy Issue identified _____

Proposed Recommendations _____

Prescriber Response

- Please implement proposed recommendation
- Please implement the following changes: _____

(Please Fax necessary prescriptions.)

- Please have the patient schedule an appointment with my office

Prescriber Signature _____

Thank you for your attention to this matter!

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA