Pharmacy Change Order Request Form (Available online at [www.inspect.in.gov](http://www.inspect.in.gov))

Indiana Scheduled Prescription Electronic Collection & Tracking

*.protecting hoosiers one prescription at a time*

**Required Field**

**Pharmacy Change Order Request**

Change Order Number: AB0000000

Pharmacist DOB: MM/DD/YYYY

Pharmacy Name: IBH Pharmacy

Pharmacist Name: Joe Smith

Pharmacy NABP: 1534422

Pharmacist Professional License Number:

**Pharmacy Contact Information**

Address Line 1: 

Email Address: 

Address Line 2: 

City: 

Address Line 3: 

State/Province: Indiana

Telephone Number: 

Zip/Postal Code: 

Fax Number: 

Country/Region: United States

**Disclaimer**

I (the Dispenser/Practitioner) attest that I am not submitting a change order request under false pretense in an effort to alter or fabricate patient information. I understand that all valid or invalid data modifications are solely my responsibility as the dispenser/practitioner.

I understand that INSPECT is under no obligation to investigate the validity of my Pharmacy Change Order Request and Digital Signature (Notwithstanding my pharmacy NABP number, professional license number, DEA number, my date of birth and name). I am duty-bound to abide
by all applicable Federal and State guidelines including, but not limited to, IC-35-48-7 and The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Misuse of INSPECT's data constitutes a criminal offense and may result in the suspension/revocation of access privileges, or, in some cases, action against offending accountholder's and/or agent's professional license.

I acknowledge/agree to the Electronic Signature Agreement

Reason for Change

Changes Requested

The Following Areas Can Be Modified:

PRESCRIBER INFO:

- DEA Number (If the prescription reported has been attributed to the wrong prescriber)

Here you should provide the Rx number of the errant record along with the correct DEA number that the prescription should be attributed too, the fill date, and the patient's last name. (The fill date, last name, and Rx # are located on the .pdf for that DEA number) The DEA number should always be verified by checking the hard copy prescription itself. If you believe the DEA number is correct, please provide the doctors full name.

DATE INFORMATION:

- Rx Written (If the written date reported for the prescription is incorrect)
- Rx Filled (If the filled date reported for the prescription is incorrect)

Since date information should be provided in the box above, you may leave this box blank.

PRESCRIPTION SPECIFIC INFO:

- Rx Number (If the prescription number reported is incorrect)
- Refill Code (If the code indicating whether the prescription is new or a refill is incorrect)
- Days Supply (If the estimated number of days the prescription will last is incorrect)
• Quantity (If the metric units of drug being dispensed is incorrect)

You may leave this box blank.

If the errant DEA number applies to more than one patient’s records, you may leave this section blank.

**Signatures**

In order to modify existing records within the prescription management program system, you, or your authorized representative, will be required to use an electronic signature. Please be aware that an electronic signature is as legally binding as a handwritten signature. [Click here to read the full Electronic Signature Agreement](www.inspect.in.gov)

**Requested By:**

Your Name Goes Here

**Date:**

**Modified By:** (INSPECT Staff Person) **Date:**