

DATE: \_\_\_\_\_ NEEDS BY DATE: \_\_\_\_\_ SHIP TO:  PATIENT  OFFICE  OTHER \_\_\_\_\_

PATIENT INFO	
Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

PRESCRIBER INFO		
Prescriber Name		
DEA#	NPI#	License#
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

**INSURANCE:** PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

## CLINICAL INFORMATION

Diagnosis: \_\_\_\_\_

Clinical Information (if applicable)  
 Weight: \_\_\_\_\_

## PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
<input type="checkbox"/> Lovenox Enoxaparin	30 mg/ 0.3 ml			
<input type="checkbox"/> Lovenox Enoxaparin	40 mg/ 0.4 ml			
<input type="checkbox"/> Lovenox Enoxaparin	60 mg/ 0.6 ml			
<input type="checkbox"/> Lovenox Enoxaparin	80 mg/ 0.8 ml			
<input type="checkbox"/> Lovenox Enoxaparin	100 mg/ 1.0 ml			
<input type="checkbox"/> Lovenox Enoxaparin	120 mg/ 0.8 ml			
<input type="checkbox"/> Other				

By signing this form, Cienega Pharmacy and it's staff are authorized to serve as your prior authorization designated agent for medical and prescription insurance companies.

\_\_\_\_\_  
 Prescriber's Signature (no stamps) \_\_\_\_\_ Date \_\_\_\_\_  
 If Brand required check  DAW

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