LOW MOLECULAR WEIGHT REFERRAL FORM

Updated July 2019

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides
Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code ☐ _____ Diagnosis _____
Duration of treatment: From: _____ To: _____
☐ **Yes** ☐ **No** Testing?
☐ **Yes** ☐ **No** Is Patient currently on therapy? Date of next blood work _____
Additional Notes: _____

PRESCRIPTION

☐ **FRAGMIN**	☐ 2,500 units/0.2ml	Syringe: _____	QTY: _____	Refill: _____
	☐ 5,000 units/0.2ml	Syringe: _____	QTY: _____	Refill: _____
	☐ 7,500 units/0.3ml	Syringe: _____	QTY: _____	Refill: _____
	☐ 10,000 units/1ml	Syringe: _____	QTY: _____	Refill: _____
	☐ 12,500 units/0.5ml	Syringe: _____	QTY: _____	Refill: _____
	☐ 15,000 units/0.6ml	Syringe: _____	QTY: _____	Refill: _____
	☐ 18,000 units/0.72ml	Syringe: _____	QTY: _____	Refill: _____
☐ **LOVENOX**	☐ 30mg/0.3ml	Syringe: _____	QTY: _____	Refill: _____
	☐ 40mg/0.4ml	Syringe: _____	QTY: _____	Refill: _____
	☐ 60mg/0.6ml	Syringe: _____	QTY: _____	Refill: _____
	☐ 80mg/0.8ml	Syringe: _____	QTY: _____	Refill: _____
	☐ 100mg/1ml	Syringe: _____	QTY: _____	Refill: _____
	☐ 120mg/0.8ml	Syringe: _____	QTY: _____	Refill: _____
	☐ 150mg/1ml	Syringe: _____	QTY: _____	Refill: _____
☐ **ARIXTRA**	☐ 2.5mg/0.5ml	Vial: _____	QTY: _____	Refill: _____
	☐ 7.5mg/0.6ml	Vial: _____	QTY: _____	Refill: _____
	☐ 10mg/0.8ml	Vial: _____	QTY: _____	Refill: _____
☐ **HEPARIN SODIUM**	☐ 5,000 units/0.2ml	Vial: _____	QTY: _____	Refill: _____
	☐ 10,000 units/0.2ml	Vial: _____	QTY: _____	Refill: _____

☐ **OTHER:** _____
Dose: _____ SIG: _____ QTY: _____ Refill: _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.

My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.