

BERGEN AVE DRUGS LOW MOLECULAR WEIGHT REFERRAL FORM

Specialty Pharmacy

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Tel 201.521.0545 | Fax 201.521.0546

Today's Date

NEW PATIENT CURRENT PATIENT

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Last updated: May 2017

Patient Name First Name Middle Name Last Name DOB _____ Weight _____ Male Female
Street Address _____ Apt # _____ City _____ State _____ Zip _____
Daytime Tel _____ Evening Tel _____ Cell _____ Email _____
Ship to Patient at Home Work **OR** Patient will pick up at Physician Office Pharmacy Date Needed _____
ICD-10 Code _____ Diagnosis _____ Duration of treatment From _____ To _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare Yes No If yes, Medicare# _____
Prescription Card Yes No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____
Street Address _____ Suite # _____ City _____ State _____ Zip _____
Tel _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

FRAGMIN

2,500 units/0.2ml Syringe _____ QTY _____ Refill X _____
5,000 units/0.2ml Syringe _____ QTY _____ Refill X _____
7,500 units/0.3ml Syringe _____ QTY _____ Refill X _____
10,000 units/1ml Syringe _____ QTY _____ Refill X _____
12,500 units/0.5ml Syringe _____ QTY _____ Refill X _____
15,000 units/0.6ml Syringe _____ QTY _____ Refill X _____
18,000 units/0.72ml Syringe _____ QTY _____ Refill X _____

LOVENOX

30mg/0.3ml Syringe _____ QTY _____ Refill X _____
40mg/0.4ml Syringe _____ QTY _____ Refill X _____
60mg/0.6ml Syringe _____ QTY _____ Refill X _____
80mg/0.8ml Syringe _____ QTY _____ Refill X _____
100mg/1ml Syringe _____ QTY _____ Refill X _____
120mg/0.8ml Syringe _____ QTY _____ Refill X _____
150mg/1ml Syringe _____ QTY _____ Refill X _____

ARIXTRA

2.5mg/0.5ml Vial _____ QTY _____ Refill X _____
7.5mg/0.6ml Vial _____ QTY _____ Refill X _____
10mg/0.8ml Vial _____ QTY _____ Refill X _____

HEPARIN SODIUM

5,000 units/0.2ml Vial _____ QTY _____ Refill X _____
10,000 units/0.2ml Vial _____ QTY _____ Refill X _____

OTHER

_____ QTY _____ Refill X _____

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

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

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