Lumicera
Health Services

FAX COVER SHEET

Date: _____

Pages: _____
(including cover sheet)

Refill Authorization Request Form

Toll Free: 855-847-3553

Rx Number: _____ DOB: _____
Patient: _____ Phone: _____
Address: _____ Doctor: _____
Prescribed Drug: _____ Last Fill: _____
SIG: _____ QTY: _____
_____ Refills Authorized: _____

Physician Response: (select only one response)

- ○ Approve **one** more refill only
- ○ Approve a qty of _____ and give _____more refills
- ○ No further refills approved. Patient must see doctor.
- ○ Give only enough for one day. Patient must see doctor.
- ○ Have patient call doctor.
- ○ Changes to Rx: _____

Authorized By: _____ Date: _____/_____/_____

DEA #: _____

Please respond to this request by filling out this form and returning it by facsimile.

Fax: 855-847-3558
