



Specialty Medical

DRUGSTOREFAX: 1-888-978-7947 | PHONE: 1-888-795-5826 | WEBSITE: SMDrugstore.com | EMAIL: Pharmacy@smdrugstore.com**PLEASE NOTE:** Only healthcare providers can e-prescribe/fax to Specialty Medical Drugstore

Patient Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	Drug/Food Allergies:
Address:	City:	State:	Zip:
Phone# (Home):	Phone# (Mobile):		
Date of Birth:	Email for tracking required:		
Known Medical Conditions:	Other Medications:		

SMDrugstore does not share information, including email. Email will be used for order status and tracking only.

EnLyte® NDC: 64661-0711-30

Quantity: 90 Capsules or _____

SIG: Take 1 Capsule by mouth daily or _____

*Refills: 0_1_2_3_1YR_ or _____

Prescriber Signature:	Written Date:		
Phone #:	Fax #:		
Prescriber Address:	City:	State:	Zip:
Prescriber Name:	NPI/DEA Required:		

MUST BE COMPLETED BY CUSTOMER - Login at SMDrugstore.com, create a profile, place your order and make payment, or include credit card for payment below. Have your physician ecribe or fax your prescription. Thank you.

 30 CAPSULES OF EnLyte® FOR **\$62.00** Insurance _____ RX BIN # _____ PCN _____ 60 CAPSULES OF EnLyte® FOR **\$124.00** Cardholder ID _____ 90 CAPSULES OF EnLyte® FOR **\$180.00** Group _____

****All orders are subject to a \$4.95 shipping fee (order online at smdrugstore.com) and a \$5.00 convenience fee if ordered over the phone**

 FOR AUTOMATIC REFILLS (Same card and address will be used each time) please sign below

I authorize **SPECIALTY MEDICAL DRUGSTORE** to charge my credit card for the amount indicated.

Credit Card Number: _____ Expiration Date: _____

CVC Code: _____ (3 digit code on back of card. If Amex the 4 digit code on the front of the card)

Customer Signature _____