



Prescriber Fax Form

Date: _____

Patient's Name: _____

Patient's Phone #: _____

Patient's Email (Recommended): _____

Patient's DOB: _____

NEW START PROMO:

I would like my patient to receive their first 60 days for only \$59.90

(\$1/day) (check box):

Provider's Name: _____

Provider's Phone Number: _____

Notes: _____

Fax: 1-985-778-2463

Phone: 985-629-5825 | website: www.enlyterx.com