

**CVS/pharmacy**



**REQUEST FOR A REFILL OR NEW PRESCRIPTION**

AUTO-FAX ELECTRONICALLY TRANSMITTED: 08-18-2020 20:05

8873

Low

2.6.2020

**PRESCRIBER:**

Name: RAFAEL ROMERO  
Address: 527 N PALM AVESTE 106  
ONTARIO, CA 917623215

From: **CVS/pharmacy**  
Store #: 9729  
Address: 2238 S. EUCLID AVE., SUITE A  
ONTARIO, CA 91762

Phone: 909-391-3423  
Fax: 909-391-3424  
[Orig. Prescriber:

Phone: 909-391-0263  
Fax: 909-395-8487

**Patient expects to pick-up prescription at:** 08-24-2020 at 12:00

**FOR PATIENT:**

Name: MUSMAN, OCTORIA  
DOB: 10-29-1974  
Address: 2118 S BONITA AVE  
ONTARIO, CA 91762  
Phone: 909-527-0501

**FOR ORIGINAL PRESCRIPTION:**

CVS Rx#: 734598  
Medication: FLUTICASONE PROP 50 MCG SPRAY  
Qty. Prescribed: 16.0 GM Sixteen  
Prescribed Refills: 1  
Date Written: 05-27-2020  
SIG: USE 2 SPRAYS IN EACH NOSTRIL DAILY

Date Last Filled: 07-01-2020


Pharmacy Comments:

**\*\*This Prescription is valid only if transmitted by means of a facsimile machine\*\***

**PRESCRIBER ACTION REQUIRED:**

- ☒ Authorized this time plus 5 additional refills  
☐ Not Authorized

Prescriber Comments:

Prescriber's Name (Printed): _____	Prescriber's DEA #: _____
Transmitted by: _____ (KS/TX ONLY)	DPS # / Oral Code: _____ (TX/HI ONLY)
Prescriber's Signature: 	Date: <u>8-20-2020</u>
Massachusetts Only: Interchange is mandated unless Practitioner writes the words "No Substitution"	

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**FOR CVS USE ONLY:** SRX1 29000000004607517487

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