☒ **Urgent** ☒ **Reply ASAP**

To:	From:
RE Patient:	Date:
Phone Number:	Sender's Phone Number:
Fax Number:	Sender's Fax Number:

Pages Including Cover: 2

---Patient Information Sheet---
PLEASE COMPLETE AND FAX BACK ASAP TO:

Date of Last Visit: _____

Reason for Visit: _____

_____

Allergies: _____

_____

Current Medications: _____

_____

_____

Affected Area: _____

_____

Please remember to circle quantity and refill amount for the attached RX your patient has requested from our company.

PAT ID #:

Rx Form PLEASE COMPLETE AND SEND TO PHARMACY

Patient Name:_____ **DOB:**_____ **Prescriber/Supervising Physician:**_____

Street Address:_____ **NPI:**_____ **DEA:**_____

City/State/Zip:_____ **Phone:**_____ **Email:**_____

Phone:_____ **Email:**_____ **Address:**_____

Allergies: NKDA **City/State/Zip:**_____

Medications: None indicated **Phone:**_____ **Fax:**_____

PAIN MANAGEMENT: LOCAL ANESTHETIC (SELECT 1)

☐ **Pliaglis (Lidocaine 7% Tetracaine 7% Cream)** Qty: 180 gms Refills:_____ Default: 3
Sig: Apply 1 to 2 grams to affected are topically 2 to 3 times a day. Peel off after waiting the required application time as directed.(max application time of 60 minutes).

☐ **Lidocaine 5% Ointment** Sig: Apply 2 to 3 grams to affected area topically 3 to 4 times a day. Qty: 250 gms Refills:_____ Default: 3

☐ **Lidocaine 2.5% Prilocaine 2.5% Cream** Sig: Apply 2 to 3 grams to affected area topically 3 to 4 times a day. Qty: 240 gms Refills:_____ Default: 3

INFLAMMATION MANAGEMENT: NON-STEROIDAL (SELECT 1)

☐ **Diclofenac 3% Topical Gel** Sig: Apply 2-3 gms to affected area(s) 3-4 times a day (1gram = 1 dime size). Qty 300 gms Refills:_____ Default: 3

INFLAMMATION MANAGEMENT: STEROID (SELECT 1)

☐ **Diflorasone Diacetate Ointment 0.05%** Sig: Apply 1 to 2 grams to affected area topically 2 to 3 times a day. Maximum use 50grams per week. Qty: 180 gms Refills:_____ Default: 3

☐ **Hydrocortisone Butyrate Lotion 0.1%** Sig: Apply 4 mls to the affected skin area 2 times daily, and rub in gently. Qty: 236 MLS Refills:_____ Default: 3

☐ **Fluocinonide 0.1% Topical Cream** Sig: Apply 1 to 2 grams to affected area topically 3 to 4 times a day. Qty: 240 gms Refills:_____ Default: 3

☐ **Clobetasol 0.05% Ointment** Sig: Apply 1 to 2 grams to affected are topically 2 to 3 times a day. Qty: 180 gms Refills:_____ Default: 3

☐ **Desoximetasone 0.05% Cream** Sig: Apply 1-2 grams to affected area(s) 1-2 times daily. Qty: 120 gms Refills:_____ Default: 3

☐ **Triamcinolone Acetonide 0.147 mg/gm Topical Aerosol** Sig: Apply 2-3 sprays to affected area(s) 3-4 times daily (2 second spray = 1 gram). Qty: 400 gms Refills:_____ Default: 3

☐ **Calcipotriene 0.005%/ Betamethasone Dipropionate 0.064%** Sig: Apply a thin layer (up to 5 grams) to the affected area twice daily. Qty: 3~0 gms Refills:_____ Default: 3

ORAL NSAID (SELECT 1)

☐ **Fenoprofen 200mg Capsule** Sig: Take 1-2 capsules by mouth up to 4 times daily. Qty 240 Caps Refills:_____ Default: 3

☐ **Ketoprofen 25 mg Capsule** Sig: Take 1-2 capsules by mouth up to 4 times daily. Qty 240 Caps Refills:_____ Default: 3

☐ **Naproxen Oral Suspenion (125MG/5ML)** Sig: Take 10-20ml by mouth twice daily as needed for pain. Qty 946 ML Refills:____ Default:3

☐ **Indomethacin Oral Capsule 20 MG** Sig: Take 1 capsules by mouth three times daily for pain. Qty 90 Caps Refills:_____ Default: 3

ORAL MUSCLE RELAXANT (SELECT 1)

☐ **Chlorzoxazone 375mg Tablet** Sig: Take 1 tablet by mouth 3-4 times daily as needed for muscle spasm. Qty: 120 Tabs Refills:_____ Default: 3

☐ **Chlorzoxazone 250mg Tablet** Sig: Take 1 tablet by mouth 3-4 times daily as needed for muscle spasm. Qty: 120 Tabs Refills:_____ Default: 3

☐ **Cyclobenzaprine 7.5mg Tablet** Sig: Take one tablet by mouth up to 4 times daily as need muscle spasm. Qty: 120 Tabs Refills:_____ Default: 3

☐ **Metaxalone 800mg Tablet** Sig: Take 1 tablet by mouth 3-4 times daily. Qty: 120 Tabs Refills:_____ Default: 3

SKIN EMOLLIENT

☐ **Phalg Rx Skin Emulsion** Sig: Use 1-2 sprays on affected area and let dry re apply upto 4 times a day or as needed. Qty: 240 mls Refills:_____ Default: 3

PSORIASIS / SCAR (SELECT 1)

☐ **Calcipotriene 0.005% Topical Cream** Sig: Apply 2-3 gm to affected area 2-3 times daily as directed. Qty: 240 gms Refills:_____ Default: 3

DIETARY SUPPLEMENT

☐ **Luvira** Sig: Take 3 capsules once daily with or without food. Qty: 90 Caps Refills:_____ Default: 3

☒ **I authorize the Pharmacist in Charge (PIC) to substitute the product prescribed with an alternative formula or product under the same therapeutic class heading on this prescription if the patient does not have insurance, has a high deductible or copay,or has an insurance policy that does not cover the particular medication that I have prescribed. I understand that the purpose of this agreement is to provide each patient with an affordable option within the same scope as the initially-prescribed medication.**

☒ **I authorize this patient's medication to be automatically refilled at the patient's request.**

Prescriber's Signature_____ **Date**_____