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PATIENT'S
NAME _____ AGE _____

ADDRESS _____ DATE _____

SUBSTITUTION PERMISSIBLE _____ M.D.

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED. THE PRESCRIBER MUST HAND WRITE "BRAND NECESSARY" OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW.

_____

OFFICE
ADDRESS _____ DEA NO. _____

REPETATUR YES ☐ NO ☐ TIMES _____ PA LC NO. _____

ITEM #52925