

RX SCRIPT

Dr.	
Address	City/State/Zip
Phone	Fax
DEA #	NPI #

FAX TO: (888)-308-2196

MUST INCLUDE FRONT AND BACK OF PATIENT'S INSURANCE CARD AND PATIENT DEMOGRAPHIC SHEET WHEN FAXING.

PATIENT INFORMATION

First Name	Last Name	Middle Initial	Date of Birth
Address	City	State	Zip
Phone	Alt. Phone		

PRESCRIPTION INSURANCE INFORMATION

Member ID #			
Rx Group #	Rx BIN #	PCN #	Carrier Phone #
Payment Type	<input type="checkbox"/> Medicare + Supplemental Insurance <input type="checkbox"/> Third Party Insurance <input checked="" type="checkbox"/> HMO/PPO <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Personal Injury/Auto/PIP <input type="checkbox"/> Cash		

SELECT DIAGNOSIS	Diagnosis <input type="checkbox"/> Back Pain <input type="checkbox"/> Knee Pain <input type="checkbox"/> Neuropathy <input type="checkbox"/> Scar Treatment <input type="checkbox"/> Arthritis <input type="checkbox"/> Post Surgery Scar <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other: _____	ICD-9: _____
SELECT ALLERGIES	Allergies <input type="checkbox"/> Aspirin/NSAIDs <input type="checkbox"/> Codeine <input type="checkbox"/> Macrolides <input type="checkbox"/> Penicillin Other (please specify): <input type="checkbox"/> Quinolone <input type="checkbox"/> Cephalosporin <input type="checkbox"/> Sulfa <input type="checkbox"/> Tetracycline _____	
SELECT FORMULA	Formula 1. <input type="checkbox"/> FTCCB - Flurbiprofen 20%, Tramadol 5%, Clonidine 0.2%, Cyclobenzaprine 4%, Bupivacaine 1% 2. <input type="checkbox"/> FTCCB - Flurbiprofen 20%, Tramadol 5%, Clonidine 0.2%, Cyclobenzaprine 4%, Bupivacaine 3% 3. <input type="checkbox"/> SCRA – (Keloids & Hypertrophic) Tamaxifen Citrate 0.1%, Tranilast 1%, Lipoic Acid 0.5%, Fluticasone 1%, Collagenase 350 U/GM Hyaluronic Acid 0.1% PRACASIL PLUS 4. <input type="checkbox"/> AWAY – (new, old, keloid scars) Fluticasone 1%, Tretinoin 0.05% Pentoxifylline 3%, PRACASIL PLUS 5. <input type="checkbox"/> FADE – (dark or hyperpigmented scars) Fluticasone 1%, Hydroquinone 8%, PRACASIL PLUS 6. <input type="checkbox"/> SUGI – (post surgical) Mupirocin 4%, Verapamil 6%, Phenytoin 2%, Betamethasone 0.1% PRACASIL PLUS	
SELECT QUANTITY	<input type="checkbox"/> 120 GM (ONE HUNDRED TWENTY GRAMS) <input type="checkbox"/> 240 GM (TWO HUNDRED FORTY GRAMS) <input type="checkbox"/> 360 GM (THREE HUNDRED SIXTY GRAMS)	
CIRCLE REFILL	Refill 1 2 3 4 5 6 PRN: _____ Other: _____	

Patient Instructions: Apply 1-3 Grams to affected area 3-4 times daily | Apply 1-2 Grams to affected area 2 times daily (Small to Medium Scars)

Alternate Instructions

Other Changes

Prescriber's Signature _____ **Date** _____

All compound topical creams are prepared in accordance with State and Federal regulations governing compounds. Compounds are available by prescription only. The FDA does not approve compounds to cure, treat, or mitigate disease. Legal Note: This fax transmission contains information belonging to the sender, which is legally confidential and privileged. This information is intended only for the recipient named above. If you are not the intended recipient you are hereby notified that any disclosure, copying, distribution, or taking any action in reliance on the contents of this faxed information is strictly prohibited.