APOTHECARY OPTIONS

Patient Name: _____**Date**: _____

Address: _____**Date of Birth**: _____

City: _____ **State**: _____ **Zip**: _____

Day Phone: (_____)_____ **Evening Phone**: (_____)_____

Diethylstilbestrol Capsules

- DES 0.5mg #100
- DES 1mg #100
- DES 2mg #100
- DES 3mg #100
- Other strength _____ Other quantity _____

Sig: 1 po daily. **Refill _____**

(Note: Patients are advised to take an 81mg aspirin daily while on DES therapy unless they are currently on prescribed anticoagulant therapy or when low-dose aspirin is contraindicated)

Prescriber Signature: _____

Prescriber Name: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

State License: _____**DEA**: _____

Phone: (_____)_____ **Fax**: (_____)_____

Instructions:

- **Complete <u>all</u> sections.**
- **We must verify the legitimacy of all prescriptions as required by law.**
- **We will contact the patient by phone to arrange for payment and shipping.**
- **Fax or mail the completed prescription to:**

APOTHECARY OPTIONS
3006 Esplanade, Suite I, Chico, CA 95973
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