Prescription Order Form

Patient Name: _____**Date**: _____

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

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

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

Apothecary Options'
Nail Fungus Solution

(Fluconazole 2%, Ketoconazole 2%, Ibuprofen 2% in DMSO)

15ml

Sig: Apply daily to affected nail and to a 1/8th inch margin of skin adjacent to the nail.

Refill _____

Prescriber Signature: _____

Prescriber Name: _____

Address: _____

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

State License: _____ **DEA**: _____

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

Instructions:

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

APOTHECARY OPTIONS
3006 Esplanade, Suite I, Chico, CA 95973
phone: 530-345-RxRx (7979) fax: 530-345-9797
toll free 1-866-586-4633