APOTHECARY OPTIONS
Prescription Request/Consult Form

Patient Name: _____ **Date**: _____

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

City: _____ **State**: **California Only** **Zip**: _____

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

Drug/Food Allergies: _____

Common Pain Cream Formulations

☐ Inflammatory Pain	☐ Neuropathic Pain	☐ Myofascial Pain	☐ Headache Pain
Diclofenac 3% Gabapentin 5% MSM 5%	Diclofenac 3% Bupivacaine 1% Gabapentin 6% Amitriptyline 2% MSM 5%	Diclofenac 3% Baclofen 2% Gabapentin 5% Cyclobenzaprine 1% Guaifenesin 5% MSM 3%	Diclofenac 3% Gabapentin 6% MSM 3% Doxepin 2%

☐ **60gm** ☐ **120gm** **Refill** _____

Sig: Apply sparingly to pain area 2-4 times daily. Massage into skin until completely absorbed.

Prescriber Signature: _____

Prescriber Name: _____

Address: _____

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

State License: _____ **DEA**: _____ ***required for Ketamine**

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

Instructions:

1. **Have your prescriber complete all the sections of this request form and sign it.**
2. **Our pharmacists will contact the prescriber directly to verify legitimacy of this information and obtain a verbal authorization and prescription as required by law. We can only ship to California addresses.**
3. **After contacting your prescriber, we will contact you to arrange for payment and shipping.**
4. **To get started, fax or mail this completed form 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 **www.apothecaryoptions.com**