Compounded Prescription Order Form

Patient Name: _____ **Date of Birth:** _____

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

Allergies: _____**Phone**: (_____) _____

Compounded Medication
☐ **Sildenafil 100mg / Apomorphine 8mg Troche** **Quantity** (circle one): 5 10 20 30 other: _____ **Refills:** _____
☐ **Tadalafil 40mg / Apomorphine 8mg Troche** **Quantity** (circle one): 5 10 20 30 other: _____ **Refills:** _____
☐ **Vardenafil 80mg / Apomorphine 8mg Troche** **Quantity** (circle one): 5 10 20 30 other: _____ **Refills:** _____
Directions: Place 1/4-1/2 troche between your gum and cheek / under your tongue 30-60 minutes prior to need once daily as needed.

Prescriber Signature: _____ **Today Date:** _____

Prescriber Printed Name: _____ ☐**MD** ☐**DO** ☐**ND** ☐**PA** ☐**NP** ☐**CNM/CN**

State License: _____ **DEA:** _____ **NPI:** _____

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

Phone: _____ **Fax:** _____ **E-mail:** _____

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