Compounded *Prescription Order Form*

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

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

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

COMPOUNDED MEDICATION

Testosterone (PPG-free) Cream

Dose: ❒ 12.5mg ❒ 25mg ❒ 75mg ❒ 100mg ❒ other:_____

NOTE: MAXIMUM DAILY DOSE OF TESTOSTERONE IS 200MG.

Container Type: ❒ EMP jar (measured in gm) ❒ Pump (measured in ml)

Qty: (gm or ml depending on container) ❒ 45 ❒ 60 ❒ 90 ❒ other: ____

Refill: _____ (Max 1 refill w/ a 90-day supply)

Directions: Apply 1 pump (= to dose ordered above) topically to skin daily.

***Maximum 90-day supply (new Rx).**
***The dispensed quantity plus refills cannot exceed 6-month supply**
*** We will call on all control prescriptions to validate legitimacy when faxed in.**

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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