BioMed SPECIALTY PHARMACY

Scar and Keloid Prescription Order Form

PH: (855) 246-6338
Please Fax to: (877) 791-7779
Secondary Fax: (248) 223-1061

Patient Information:

PLEASE FAX Patient Demographic Sheet & Prescription Insurance Card if available.

PATIENT NAME: DOB:

PRIMARY PHONE #: 2ND PHONE #:

ADDRESS: CITY, STATE, ZIP: ALLERGIES: (If no allergies please check the NKDA box)

☐ **NKDA**

Rx Medication Order:

Pharmacist Please Compound:

Rx

☐ **Formula 27 Scar Gel**

Tamoxifen 0.2%
Lipoic Acid 5%
in PracaSil™-Plus scar gel

QTY: ☐ 30gm/$85 ☐ 60gm/$149

SIG: Apply 1-2gm topically to scar daily.

ADD: ☐ Lidocaine 5%

Refills: _____

☐ **Formula 27 S Scar Gel**

Tamoxifen 0.2%
Lipoic Acid 5%
Betamethasone Val 0.1%
in PracaSil™-Plus scar gel

QTY: ☐ 30gm/$95 ☐ 60gm/$169

SIG: Apply 1-2gm topically to affected area daily.

ADD: ☐ Lidocaine 5%

Refills: _____

Notes:

For studies on PracaSil™-Plus scar gel visit https://elitemedicalplus.com/casestudies

Prescriber Information:

PRESCRIBER'S SIGNATURE:

NPI# or DEA# (CTP# for CNPs only): DATE:

ADDRESS, CITY, STATE, ZIP:

PHONE #: FAX #:

This form is proprietary of BioMed Pharmacy and is only intended for use between provider and patient. Any unauthorized use could result in legal action. This facsimile transmission is intended to be delivered to the named addressee and may contain information that is confidential, privileged, and proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the names addressee, the recipient should immediately notify the sender at the address and/or telephone number set forth herein and obtains instructions as to the disposal of the transmitted material. In no event should such material be read or retained by anyone other than the addressee, except by express authority of the sender to the named addressee **FDA does not review compounded medication for safety or efficacy.**

BioMed SPECIALTY PHARMACY

Scar and Keloid Prescription Order Form

PH: (855) 246-6338
Please Fax to: (877) 791-7779
Secondary Fax: (248) 223-1061

Patient Information: PLEASE FAX Patient Demographic Sheet & Prescription Insurance Card if available.

PATIENT NAME: DOB:

PRIMARY PHONE #: 2ND PHONE #:

ADDRESS: CITY, STATE, ZIP: ALLERGIES: (If no allergies please check the NKDA box)

☐ NKDA

Rx Medication Order: *Pharmacist Please Compound:*

Rx

☐ Formula 27 Scar Gel

Tamoxifen 0.2%
Lipoic Acid 5%
in PracaSil™-Plus scar gel

QTY: ☐ 30gm/$85 ☐ 60gm/$149

SIG: Apply 1-2gm topically to scar daily.

ADD: ☐ Lidocaine 5%

Refills: _____

☐ Formula 27 S Scar Gel

Tamoxifen 0.2%
Lipoic Acid 5%
Betamethasone Val 0.1%
in PracaSil™-Plus scar gel

QTY: ☐ 30gm/$95 ☐ 60gm/$169

SIG: Apply 1-2gm topically to affected area daily.

ADD: ☐ Lidocaine 5%

Refills: _____

Notes:

For studies on PracaSil™-Plus scar gel visit https://elitemedicalplus.com/casestudies

Prescriber Information:

PRESCRIBER'S SIGNATURE:

NPI# or DEA# (CTP# for CNPs only): DATE:

ADDRESS, CITY, STATE, ZIP:

PHONE #: FAX #:

This form is proprietary of BioMed Pharmacy and is only intended for use between provider and patient. Any unauthorized use could result in legal action. This facsimile transmission is intended to be delivered to the named addressee and may contain information that is confidential, privileged, and proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the names addressee, the recipient should immediately notify the sender at the address and/or telephone number set forth herein and obtains instructions as to the disposal of the transmitted material. In no event should such material be read or retained by anyone other than the addressee, except by express authority of the sender to the named addressee FDA does not review compounded medication for safety or efficacy.

27S27
080421_GEN