

Patient Information:		<i>PLEASE FAX with Patient Demographic Sheet and State Issued Photo ID</i>	
FIRST NAME:	LAST NAME:	ADDRESS:	
DATE OF BIRTH:	PRIMARY PH #:	CITY, STATE, ZIP:	
		ALLERGIES: (If no allergies please check the NKDA box) <input type="checkbox"/> NKDA	

Rx Medication Order:	Pharmacist Please Compound:	Compounded testosterone is free of any gluten, casein, dyes, sulfates and parabens. We can also eliminate the use of any ingredient the patient is allergic to.
<input type="checkbox"/> Testosterone # 31 Formula (micronized, male dosing) Please choose strength and quantity by checking the appropriate box		
Strength: <input type="checkbox"/> 50mg (5%) (per gram of base)	Quantity: <input type="checkbox"/> 30gm/\$53 <input type="checkbox"/> 60gm/\$105 <input type="checkbox"/> 90gm/\$147	Base: <input type="checkbox"/> Cream <input type="checkbox"/> Gel (choose one base)
<input type="checkbox"/> 75mg (7.5%)	<input type="checkbox"/> 30gm/\$59 <input type="checkbox"/> 60gm/\$114 <input type="checkbox"/> 90gm/\$157	SIG: Apply 1gm topically to upper arm or shoulder QAM
<input type="checkbox"/> 100mg (10%)	<input type="checkbox"/> 30gm/\$65 <input type="checkbox"/> 60gm/\$125 <input type="checkbox"/> 90gm/\$169	
<input type="checkbox"/> 150mg (15%)	<input type="checkbox"/> 30gm/\$74 <input type="checkbox"/> 60gm/\$144 <input type="checkbox"/> 90gm/\$189	
<input type="checkbox"/> Other: _____ mg Quantity= _____ gm		Refill: _____

Prescriber Information:	Contact Information:
PRESCRIBER'S SIGNATURE:	ADDRESS:
PRESCRIBER NAME (PRINT):	CITY: STATE: ZIP:
DEA# DATE:	PHONE #: FAX #:

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**BM Half WEB
MALETST20
101419**

Tear Here

Patient Information Sheet

(Provider, please hand this sheet to the patient.)

Dear Patient,

We have sent your special order prescription to BioMed Specialty Pharmacy to be compounded.

BioMed Specialty Pharmacy will call you within 24-48 hours from the phone number (855) 246-6338.

If you don't hear from them within 24-48 hours please call them back at (855) 246-6338.

BioMed's business hours are Monday-Friday 8am-6pm.

What information does BioMed need?



- Your Driver's License or State Issued ID number
- A credit card to secure payment
- Any allergies to any medications

biomedrelief.com

Ph: 855. 246. 6338

info@biomedpharmacy.com