

Patient Information: PLEASE FAX with Patient Demographic Sheet & Rx Insurance Card

REQUIRED	FIRST NAME: _____	LAST NAME: _____	Additional Info	ADDRESS: _____
	PRIMARY PH #: _____	SECOND PH #: _____		CITY, STATE, ZIP: _____
	DATE OF BIRTH: _____	<input type="checkbox"/> Check here if this is a Worker's Comp or Auto Claim prescription.		EMAIL ADDRESS: _____
	ALLERGIES: _____			LAST 4 DIGITS OF SSN: _____

Rx Medication Order: Pharmacist Please Compound: You may change the directions, or delete / substitute / add any additional medications for all formulations.

3. Formula

Ketamine HCl 10% + Gabapentin 6%
Amitriptyline HCl 2% + Baclofen 2%
Cyclobenzaprine HCl 2%
Diclofenac sodium 3%
Lidocaine 5%

Refill: _____

QTY (gm): 240 _____ Other _____

SIG: Apply 1-2gm topically to affected area TID-QID

5. Formula

Diclofenac sodium 3%
Gabapentin 6%
Lidocaine 2%
Prilocaine HCl 2%

Refill: _____

QTY (gm): 240 _____ Other _____

SIG: Apply 1-2gm topically to affected area TID-QID

7. Formula

Diclofenac sodium 3%
Ketoprofen ultra micronized 3%
Piroxicam 2% + Gabapentin 3%
Amitriptyline HCl 2%
Cyclobenzaprine HCl 2%
Lidocaine 2%

Refill: _____

QTY (gm): 240 _____ Other _____

SIG: Apply 1-2gm topically to affected area TID-QID

8D. Formula

Diclofenac sodium 3%
DMSO 10% + Gabapentin 6%
Amitriptyline HCl 2%
Cyclobenzaprine HCl 2%
Lidocaine 4%

Refill: _____

QTY (gm): 240 _____ Other _____

SIG: Apply 1-2gm topically to affected area TID-QID

Rx:

QTY: _____ Refill: _____

Directions: _____

Rx:

QTY: _____ Refill: _____

Directions: _____

(OPTIONAL) ADDITIONAL INSTRUCTIONS or COMPOUNDS:

(OPTIONAL) ADD-ON INGREDIENTS: CHECK ONE OF THE FOLLOWING TO ADD ON TO ANY FORMULA

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Amantadine HCl 8% (NMDA Antagonist) | <input type="checkbox"/> Desoximetasone micronized 0.25% (Steroid) | <input type="checkbox"/> Clonidine HCl 0.2% (Sympathetic) | <input type="checkbox"/> Nifedipine 5% (Vasodilator) |
| <input type="checkbox"/> Orphenadrine citrate 5% (NMDA Antagonist) | <input type="checkbox"/> Dimethyl Sulfoxide (DMSO) 5% (Penetrant Enhancer) | <input type="checkbox"/> Cyclobenzaprine HCl 2% (Muscle Relaxer) | |

We have many additional formulas available to meet your patients' needs! Call our Pharmacists today! 248. 663. 3390



I, the prescriber signing below, authorize the pharmacist to change to a compound covered by the patient's third-party insurance.

Prescriber Information:

PRESCRIBER'S SIGNATURE: _____

PRESCRIBER NAME (PRINT): _____

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

Contact Information:

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ FAX #: _____

* Aids in relieving the symptoms of these conditions and specialties. The information provided herein is for reference only and is not to be relied upon as making any representation as to the efficacy of any particular formulations. Nothing herein is intended to replace the independent judgement of a licensed professional. 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 named addressee, the recipient should immediately notify the sender at the address and/or telephone number set forth herein and obtain 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.

START SENDING SCRIPTS TO



STEP 1: Fill out the top portion.

Have the patient's demographic sheet and Rx Insurance Card available.

Patient Information:		PLEASE FAX with Patient Demographic Sheet & Rx Insurance Card	
REQUIRED	FIRST NAME: <i>JANE</i>	LAST NAME: <i>DOE</i>	Additional Info
	PRIMARY PH #: <i>(313) 555-1234</i>	SECOND PH #: <i>(248) 123-5555</i>	
	DATE OF BIRTH: <i>03/18/64</i>	<input type="checkbox"/> Check here if this is a Worker's Comp or Auto Claim prescription.	
	ALLERGIES: <i>none known</i>		
	ADDRESS: <i>1234 CHERRY LANE</i>		
	CITY, STATE, ZIP: <i>DETROIT, MI 48235</i>		
	EMAIL ADDRESS: <i>jane@doe.com</i>		
	LAST 4 DIGITS OF SSN: <i>3456</i>		

STEP 2: Check the meds you wish to prescribe, or write your own in the blank space provided. Include quantity and refills.

<input checked="" type="checkbox"/> # 5. Formula
Diclofenac sodium 3%
Gabapentin 6%
Lidocaine 2%
Prilocaine HCl 2%
Refill: <i>2</i>
QTY (gm): <input checked="" type="checkbox"/> 240 <input type="checkbox"/> Other
SIG: Apply 1-2gm topically to affected area TID-QID

STEP 3: Sign and date the bottom portion.

Prescriber Information:	Contact Information:
PRESCRIBER'S SIGNATURE: <i>[Signature]</i>	ADDRESS: <i>1234 MAIN STREET, SUITE 23</i>
PRESCRIBER NAME (PRINT): <i>JOHN SMITH, MD</i>	CITY: <i>DETROIT</i> STATE: <i>MI</i> ZIP: <i>48017</i>
NPI# or DEA# (CTP# for CNPs only): <i>782347382</i>	PHONE #: <i>313-555-5555</i> FAX #: <i>248-555-5555</i>
DATE: <i>09/04/13</i>	

STEP 4: Fax directly to our pharmacy!

With demographic sheet and Rx Insurance Card.

A Service Liaison can program BioMed Formulations into your EMR upon request.

BioMed will provide:

- Free & Reliable Delivery or Shipping to the patient's home
- Education and Counseling on medications and treatment

Fax: 877. 791. 7779

Ph: 855. 246. 6338

23815 Northwestern Hwy.
Southfield, MI 48075



www.biomedpharmacy.com
www.targetedpaincontrol.com

Your physician has chosen **BioMed Specialty Pharmacy** to create your personalized compounded prescription.

A member of BioMed's Customer Service Team will call you shortly to discuss your prescription.

If you do not hear from us within 24 hours, please contact our pharmacy.

Ph: 855. 246. 6338

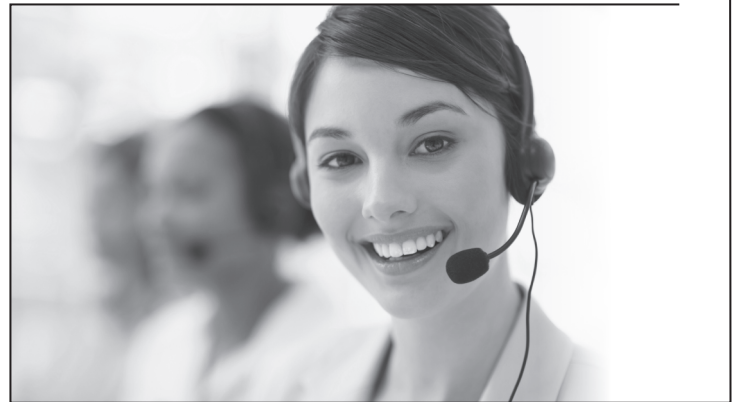
info@biomedpharmacy.com

Mon - Fri: 8am - 6pm

What information does BioMed need?

It would be extremely helpful to our team if the following information is readily available at the time of our call:

- Your prescription insurance card
- Your Social Security number
- A credit card to secure payment



What insurance information is needed?

The highlighted information will be collected. ► Keep in mind, your card may vary in design. Some information may be located on the back.

Will my insurance cover my compounded prescription?

BioMed will verify your coverage and discuss your copay obligation. If your insurance does not cover compounded formulations, we are able to offer you several discounted out-of-pocket pricing options.

Rx Prescription Insurance Card

Could also be represented as:

MEMBER NAME:
FIRST M LASTNAME

RxGROUP:
XXXXXXXXXXXXXXXXXX

"RxGRP"
"GROUP"
"GRP#"

MEMBER ID #:
XXXXXXXXXXXXXXXXXX

RxBIN #:
XXXXXXXXXXXXXXXXXX

"BIN#"
"BIN"

EMPLOYER NAME:
A COMPANY LLC

RxPCN:
XXXXXXXXXXXXXXXXXX

"PCN#"
"PCN"

Could also be represented as:
"CARD #" "ENROLLEE ID" "ID No" "ID #"