

PAIN MANAGEMENT

Prescription Order Form

PH: (855) 246-6338

Please Fax to:
(877) 791-7779

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.*

<p><input type="checkbox"/> # 5. Formula</p> <p>* Mild Neuropathic Pain Diclofenac sodium 3% Gabapentin 6% Lidocaine 2%</p> <p>* General Pain Prilocaine HCl 2%</p> <p>* Inflammation</p> <p>QTY (gm): <input type="checkbox"/> 240 <input type="checkbox"/> _____ <small>Other</small></p> <p>SIG: Apply 1-2gm topically to affected area TID-QID</p> <p style="text-align: right;">Refill: _____</p>	<p><input type="checkbox"/> # 5C. Formula</p> <p>* Moderate Neuropathic Pain Clonidine HCl 0.2% + Diclofenac sod 5% Gabapentin 6% + Amitriptyline HCl 2% Cyclobenzaprine HCl 2% Magnesium chloride hexahydrate 3%</p> <p>* Muscle Pain</p> <p>* Inflammation</p> <p>QTY (gm): <input type="checkbox"/> 240 <input type="checkbox"/> _____ <small>Other</small></p> <p>SIG: Apply 1-2gm topically to affected area TID-QID</p> <p style="text-align: right;">Refill: _____</p>	<p><input type="checkbox"/> # 5U. Formula</p> <p>* Severe Neuropathic Pain Ketamine HCl 5% + Diclofenac sod 5% Gabapentin 6% + Amitriptyline HCl 2% Cyclobenzaprine HCl 2% Magnesium chloride hexahydrate 3%</p> <p>* Severe Pain</p> <p>* Muscle Pain</p> <p>* Joint Pain</p> <p>QTY (gm): <input type="checkbox"/> 240 <input type="checkbox"/> _____ <small>Other</small></p> <p>SIG: Apply 1-2gm topically to affected area TID-QID</p> <p style="text-align: right;">Refill: _____</p>
<p><input type="checkbox"/> # 7. Formula</p> <p>* Sprains Diclofenac sodium 3% Ketoprofen 3%</p> <p>* Strains Piroxicam 2% + Gabapentin 3% Amitriptyline HCl 2% Cyclobenzaprine HCl 2% Lidocaine 2%</p> <p>* Muscle Pain</p> <p>* Persistent Pain</p> <p>* Arthritis</p> <p>* Inflammation</p> <p>QTY (gm): <input type="checkbox"/> 240 <input type="checkbox"/> _____ <small>Other</small></p> <p>SIG: Apply 1-2gm topically to affected area TID-QID</p> <p style="text-align: right;">Refill: _____</p>	<p><input type="checkbox"/> # 8D. Formula</p> <p>* Deep Tissue Pain Diclofenac sodium 3% DMSO 10% + Gabapentin 6% Amitriptyline HCl 2% Cyclobenzaprine HCl 2% Lidocaine 4%</p> <p>* Arthritis</p> <p>* Back Pain</p> <p>* Persistent Pain</p> <p>* Joint Pain</p> <p>* Bursitis</p> <p>QTY (gm): <input type="checkbox"/> 240 <input type="checkbox"/> _____ <small>Other</small></p> <p>SIG: Apply 1-2gm topically to affected area TID-QID</p> <p style="text-align: right;">Refill: _____</p>	<p><input type="checkbox"/> # 3. Formula</p> <p>* Severe Neuropathic Pain Ketamine HCl 10% + Gabapentin 6% Amitriptyline HCl 2% + Baclofen 2% Cyclobenzaprine HCl 2% Diclofenac sodium 3% Lidocaine 5%</p> <p>* Severe Pain</p> <p>* Fibromyalgia</p> <p>* TGN</p> <p>* Muscle Pain</p> <p>* Inflammation</p> <p>QTY (gm): <input type="checkbox"/> 240 <input type="checkbox"/> _____ <small>Other</small></p> <p>SIG: Apply 1-2gm topically to affected area TID-QID</p> <p style="text-align: right;">Refill: _____</p>
<p><input type="checkbox"/> # 2. Formula</p> <p>* Complex Regional Pain Syndrome Ketamine HCl 10% + Pentoxifylline 6% + Clonidine HCl 0.2% + Dimethyl Sulfoxide (DMSO) 10%</p> <p>QTY (gm): <input type="checkbox"/> 240 <input type="checkbox"/> _____ <small>Other</small></p> <p>SIG: Apply 1-2gm topically to affected area TID-QID</p> <p style="text-align: right;">Refill: _____</p>	<p><input type="checkbox"/> # 1. Formula</p> <p>* Shingles Ketamine HCl 10% + Acyclovir 5% Amitriptyline HCl 2% + Lidocaine 2% Carbamazepine micronized 2%</p> <p>* Postherpetic Neuralgia</p> <p>QTY (gm): <input type="checkbox"/> 240 <input type="checkbox"/> _____ <small>Other</small></p> <p>SIG: Apply 1-2gm topically to affected area TID-QID</p> <p style="text-align: right;">Refill: _____</p>	

(Optional) Additional instructions or compounds

* Commonly requested for

(Call pharmacist for additional formulas/conditions)

I, the prescriber signing below, authorize the pharmacist to change to a compound covered by the patient's third-party insurance.
To uncheck this statement box please initial here _____

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 Pharmacy Venture Consultants, LLC 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. As always, the FDA does not review any compounded medication for safety of efficacy.