

Account #

\*Email tracking to:

Account Open Date

**MUST CHECK ONE**

Fax: 407-673-1234

Bill Physician Bill Patient

This is a refill

Clinic/ Physician name:

Phone:

Address:

City:

ST:

Zip:

**MUST CHECK ONE**

Ground

2nd Day

Overnight

**PATIENT INFORMATION**

Name:

DOB:

Address:

City:

State:

Zip:

Phone:

Email

**MUST CHECK ONE:**

Patient will pick-up at pharmacy

Ship to patient address

Ship to office address

503B Label	Papaverine mg/ml	Phent. mg/ml	PGE mcg/ml	Atropine mg/ml
PGE1			40	
PGE2			80	
PGE3			150	
BM3	30	3		
T-50	8	0.29	2.9	
NB-143	30	3	10	
NB-243	30	3	20	
NB-343	30	3	30	
T-101	17.65	0.59	5.9	
T-105	30	1	10	
T-106	30	1	25	
SB4	30	3	40	
SB5	30	3	50	
SB6	30	3	60	
ST2	30	3	100	
RE1	30	3	200	
RE2	30	3	300	
FormF1	1.8	0.2	18	.02
QM1	30	3	10	0.2
QM2	30	3	60	0.2
QM3	30	3	150	0.2
QM4	30	3	300	0.2
FormF9	0.9	0.1	20	.01
FA	20	2	20	0.2



**"Reversal Medication" in case of priapism**  
Include Phenylephrine 1mg/ml 5ml



Dispense Qty: 2.5ml 5ml 10ml # of syringes / bags of 10 2 / 1cc | 30 gauge | 1/2" | alcohol swabs Autoject II

Sig:

Physician Name (Print):

Physician Signature:

Date:

NPI:

Phone:

Refills: