Topical Pain Management

Order Form

Patient Name:_____
Address: _____
City: _____State: _____ Zip: _____
DOB: _____ Allergies: _____
Phone Number: ( ) _____
New Patients: Fax current insurance information with Rx

Doctor Name: _____
Address: _____
City: _____ State: _____ Zip: _____
DEA# _____ NPI # _____
Office Phone: ( ) _____ Contact: _____

COMMON FORMULATIONS:

* NOTE: CROSS OUT ANY UNWANTED MEDICATIONS IF NOT DESIRED *

ANTI-INFLAMMATORY CREAMS

_____ CASCADE DICLOFENAC 3% BACLOFEN 2% (CDB) **For** (ARTHRITIS-TENDONITIS-PLANTAR FASCITIS-EPICONDYLITIS)
_____ CASCADE DICLOFENAC 3% BACLOFEN 2% CYCLOBENZ, 2% TETRACAINE 2% (BCDT) (MUSCULOSKELETAL)

NEUROPATHIC PAIN CREAMS

**NOTE: KETAMINE IS CONTROLLED SCHEDULE III, SUBSTITUTE AMANTADINE 8%, IF DESIRED.

_____ KETAMINE 10%-BACLOFEN 2%-CYCLOBENZAPRINE 2%-GABAPENTIN 6%-LIDOCAINE 5% (KBCGL)
_____ KETAMINE 10%-CLONIDINE 0.2%-GABAPENTIN 6%-IMIPRAMINE 3%-MEFENAMIC ACID 3%-TETRACAINE 2% (KCGIMT) CREAM (RSD/CRPS-TRIGEMINAL NEURALGIA-PHANTOM LIMB PAIN-DEVELOPING NEUROPATHY)
_____ KETAMINE 10%-BACLOFEN 2%-GABAPENTIN 6%-IMIPRAMINE 3%-NIFEDIPINE 2%-TETRACAINE 2% (KBGINT) (DIABETIC & CHEMOTHERAPY INDUCED PERIPHERAL NEUROPATHY)

COMBINATION PAIN CREAMS

_____ DICLOFENAC 3%-BACLOFEN 2%-CYCLOBENZAPRINE 2%-GABAPENTIN 6%-TETRACAINE 2% (DBCGT) (TMJ, MUSCULOSKELETAL PAIN/INFLAMMATION)
_____ KETAMINE 10%-BACLOFEN 2%-CYCLOBENZAPRINE 2%-DICLOFENAC 3%-GABAPENTIN 6%-TETRACAINE 2% (KBCDGT) (RADICULOPATHY, FIBROMYALGIA)
_____ DICLOFENAC 3%-BACLOFEN 2%-CYCLOBENZAPRINE 2%-GABAPENTIN 6%-ORPHENIDRINE 5%-TETRACAINE 2% (DBCGOT) (MYOFASCIAL PAIN SYNDROME)
_____ KETAMINE 10%-CYCLOBENZAPRINE 2%-DICLOFENAC 3%-GABAPENTIN 6%-ORPHENIDRINE 5%-TETRACAINE 2% BACLOFEN 2% (KCDGOTB) (FAILED BACK SYNDROME)

QTY: Circle One: 90 GM 120 GM 180 GM 240 GM

SIG: Apply 1-2 GRAMS to affected area 3-4 times daily. OR **SIG:** _____

ADD TO FORMULATION

_____ ACYCLOVIR 5% (Anti-viral)
_____ DEOXY D-GLUCOSE(Anti-viral)
_____ BACLOFEN 2% (Neuro Pain)
_____ CLONIDINE 0.2% (vaso-dialation)
_____ CYCLOBENZAPRINE 2% (Myofascilal Pain)

_____ IMIPRAMINE 3%(Neuropathic)
_____ ORPHENADRINE 5% (Muscle NMDA Antagonist)
_____ KETOROLAC 0.5% (Acute Pain)

_____ NIFEDIPINE 2% (Tissue Perfusion)
_____ TETRACYCLINE 2% (Ectopic Impulses)
_____ VERAPAMIL 6% (Fibrosis/Scarring)
_____ MAGNESIUM CL 5%

OTHER CHANGES/Customization: _____
REFILLS: _____

PHYSICIAN'S SIGNATURE:_____ **DATE:**_____

Please fax completed form to:

The Compounding Pharmacy of America
(888) 689-9892