Patient's Name: ______________________ *D.O.B.* ____/____/____ ***Phone #:*** ______________________

Insured's Name: ______________________ *D.O.B.* ____/____/____ ***Phone #:*** ______________________
(IF NOT PATIENT) *(INSURED, IF NOT PATIENT)* *(INSURED, IF NOT PATIENT)*

Rx Insurance BIN #: ______________________ ***Rx Insurance GROUP #:*** ______________________

Rx Insurance PCN #: ______________________ ***Rx Insurance Member ID #:*** ______________________

Topical Pain Management Prescription

CHECK BOX FOR APPLICABLE PRESCRIPTION

☐ **ANTI-INFLAMMATORY** *(w/ Cox-2)*	*Celecoxib 15%, Diclofenac 3%, Gabapentin 3%, Bupivicaine 4%, Prilocaine 3%, Cetyl Myristoleate 2%*
☐ **NEUROPATHIC PAIN**	*Gabapentin 20%, Celecoxib 10%, Amitriptyline 4%, Diclofenac 3%, Baclofen 2%, Bupivicaine 2%, Cetyl Myristoleate 2%*
☐ **FIBROMYALGIA / MYOFASCIAL**	*Flurbiprofen 15%,Tramadol 5%,Gabapentin 6%, Magnesium Chloride 5%, Diclofenac 3%, Baclofen 2%, Bupivicaine 2%, Cetyl Myristoleate 2%*
☐ **ARTHRITIS / JOINT PAIN** *(w/ Cox-2)*	*Celecoxib 12%, Gabapentin 10%, Diclofenac 3%, Cyclobenzaprine 2%, Tramadol 5%, Bupivicaine 3%, Prilocaine 4%*
☐ **RAYNAUDS / PVD / CLAUDICATION**	*Arginine 12.5%, Tramadol 5%, Nifedipine 5%, Pentoxyfylline 5%, Magnesium Chloride 5%, Amitriptyline 4%, Bupivicaine 3%, Diclofenac 3%, Clonidine 0.2%, Cetyl Myristoleate 2%*
☐ **SHINGLES**	*Gabapentin 15%, Baclofen 2%, Bupivicaine 4%, Prilicaine 3%, Diclofenac 3%, Clonidine 0.2%, Deoxy-D-Glucose 0.19%, Cetyl Myristoleate 2%*
☐ **MEDICARE FORMULA** *(for Pain)*	*Gabapentin 6%, Diclofenac 3%, Prilocaine 1%, Lidocaine 1%, Meloxicam 0.09%*
☐ **SCAR FORMULA** *	*Fluticasone Propionate 0.1%, Levocetirizine Dihydrochloride 8%, Pentoxyfylline 3%, Ubiquinol 15% in Freedom Pharmaceutical Silomac Anhydrous Base*

☐ **To add Ketamine to above formulas, write "Add Ketamine" and percentage :** ______________________________

QUANTITY: **120 GM** **240 GM** **360 GM** *(1 Month's Supply)* **480 GM** *(Scar)* *Other:*__________

SIG: Apply 1-2 GRAMS to affected area 4-6 times daily *(max 12 grams daily)*
** (Scar: Apply 2-4 GRAMS to affected area 4-6 times daily- Max of 16 grams daily)*

REFILLS: **PRN** **1** **2** **3** **4** **5** *Other:*__________

** All Ingredients to be compounded in transdermal cream base vehicle*

Physician's Signature: ______________________________ ***Date:*** ______________

Physician DEA# ______________ Physician NPI# ______________