Office Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: ( ) _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: ____ /____ /_____ Phone: ( ) _____ - _____

Allergies: _____

Insured's Name: _____ ***D.O.B.*** ___ /___ /_____ ***Phone #:*** **( )** _____
(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 Pain**	**Diclofenac 3% topical gel (100 gram tube)**	**☐ 100g ☐ 200g ☐ 300g**
☐	**Anti-Inflammatory Pain**	**Diclofenac 2.31%, Lidocaine 0.577%, Prilocaine 0.577%**	**☐ 150g ☐ 300g**
☐	**Anti-Inflammatory Pain** with **Cox-2**	**Celecoxib 5%, Lidocaine 0.577%, Prilocaine 0.577%**	**☐ 150g ☐ 300g**
☐	**General Pain** (must write Ketamine – normal concentration 0.05% - 20%)	_____ **%, Gabapentin 6%, Baclofen 2%, Cyclobenzaprine 2%**	
☐	**Neuropathic Pain**	**Gabapentin 3%, Diclofenac 2.31%, Lidocaine 0.577%, Prilocaine 0.577%**	

☐ **Prescriber's Choice [include % strength of 360grams]**

include % strength of 360grams		Prilocaine	%
Diclofenac	%	Tetracaine	%
Flurbiprofen	%	Baclofen	%
Ibuprofen	%	Cyclobenzaprine	%
Ketoprofen	%	Gabapentin	%
Meloxicam	%	Amitriptyline	%
Benzocaine	%	Carbamazepine	%
Bupivacaine	%	Imipramine	%
Lidocaine	%	Acyclovir	%
	%		%
(must write Ketamine and Tramadol)			

QUANTITY: ☐ 90gm ☐ 130gm ☐ 260gm ☐ 360gm ☐ _____ gm

REFILLS: ☐ PRN ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ ___

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

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

Prescriber Name: _____ **Prescriber DEA#:** _____ **Prescriber NPI#:** _____

Signature: _____ **Date:** _____ **/**_____ **/**_____

FAX: 888 – 689 – 9892 **PHONE: 855 – 277 – 2488**