Fax Prescription, Insurance & Demographic Sheet to: **888-689-9892** **Questions? 865-963-4160**

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

Address: _____ City/ State _____ ***Zip:*** _____

Allergies: _____

Immunity Support Prescription

CHECK BOX FOR APPLICABLE PRESCRIPTION

○ **Immune Boost (Sodium Ascorbate 100 mg/ml, Glutathione 100 mg/ml, Thiamine 10 mg/ml, Pyridoxine 3 mg/ml, niacinamide 10 mg/ml)**
Quantity: 10 ml
Sig: ___IM: Inject 1 ml intramuscularly one to three times weekly
Sig:___ IV: Place 1 ml into 50 ml bag of normal saline. Infuse over 15-30 minutes

○ **Glutathione**
Quantity: 10 ml
Place calculated dose into 50-100 ml normal saline. Infuse over 30-60 minutes immediately following sodium ascorbate infusion

○ **Sodium Ascorbate (Vitamin C) 500 mg/ml**
50 ml MDV
Quantity of vials for dose: _____
Sig: Place calculated dose in required amount of intraveneous diluent (Caution: Calculate osmolarity for appropriate volume and sodium chloride content). Infuse over a minimum of 60 minutes up to three times weekly

Additional Instructions:

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

Prescriber's Signature: _____ **Date:** _____

Compounding PHARMACY OF AMERICA