



NAME:	STREET:	
DOB:		
PHONE:	CITY:	
EMAIL:	STATE:	ZIP:
ALLERGIES:		

FORMULATIONS

	Rx Quantity		
<input type="checkbox"/> Sildenafil Troches <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg	<input type="checkbox"/> #5	<input type="checkbox"/> #10	<input type="checkbox"/> #30
<input type="checkbox"/> Tadalafil Troches <input type="checkbox"/> 2.5mg <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 20mg	<input type="checkbox"/> #5	<input type="checkbox"/> #10	<input type="checkbox"/> #30
<input type="checkbox"/> ED Combination Troches (Men's Once-a-Day Troches) <input type="checkbox"/> Apomorphine 2mg, Tadalafil 5mg, Oxytocin 50 IU <input type="checkbox"/> Apomorphine 3mg, Tadalafil 10mg, Oxytocin 50 IU	<input type="checkbox"/> #5	<input type="checkbox"/> #10	<input type="checkbox"/> #30
<input type="checkbox"/> Testosterone Cream <input type="checkbox"/> 50mg/mL <input type="checkbox"/> 100mg/mL <input type="checkbox"/> 200mg/mL	<input type="checkbox"/> 30g	<input type="checkbox"/> 60g	<input type="checkbox"/> 90g

PRESCRIBER

NAME:	STREET:	
PHONE:		
FAX:	CITY:	
EMAIL:	STATE:	ZIP:
STATE LICENSE #:	DEA #:	NPI #:

SIGNATURE: _____ DATE: _____