National Pharmacy

Email Prescriptions to: orders@medmixnow.com

Fax: (323) 851-4445
Phone: (323) 851-4444
medmixnow.com

PATIENT

Name:		DOB:
Street Address:		
City:	State:	Zip:
Phone:	Email:	
Medication Allergies:		

FORMULATIONS	**Form**	**Qty**	
☐ Chlorhexidine Gel ☐ 1% ☐ 2%	Gel	☐ 30g ☐ 60g	
Directions:			
☐ Doxycycline 50mg/mL Gel	Gel	☐ 30 g ☐ 60 g	
Directions:			
☐ Minocycline Gel Kit Syringe 1: Minocycline 2% Powder Syringe 2: Mucoadhesive Gel	Gel	☐ 1 kit ☐ 2 kits ☐ 3 kits	
Directions:			

PRESCRIBER

Name:		Phone:
Street Address:		
City:	State:	Zip:
Fax:	Email:	
State License #:	NPI #:	DEA #:

Prescriber Signature: _____ Date: _____