



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

	Qty
<input type="checkbox"/> BLT: Benozcaine 20%, Lidocaine 6%, Tetracaine 4% Cream	<input type="checkbox"/> 60g
<input type="checkbox"/> BLT: Benozcaine 20%, Lidocaine 8%, Tetracaine 4% Cream	<input type="checkbox"/> 60g
<input type="checkbox"/> BLT: Benozcaine 20%, Lidocaine 10%, Tetracaine 4% Cream	<input type="checkbox"/> 60g
<input type="checkbox"/> BLT: Benozcaine 20%, Lidocaine 10%, Tetracaine 10% Cream	<input type="checkbox"/> 60g
<input type="checkbox"/> LT: Lidocaine 23%, Tetracaine 7% Cream	<input type="checkbox"/> 60g
Directions (<i>Required</i>): <input type="checkbox"/> Apply to area to be treated and remove prior to skin procedure.	
Alternate Directions:	
Quantity of Prescriptions Checked: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 (<i>Required</i>)	

PRESCRIBER

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

Prescriber Signature: _____ Date: _____