

Date _____

Patient Name _____ DOB _____

Address _____

Phone _____ Cell Phone _____

Allergies _____ NKDA

<input type="checkbox"/> Compound Naltrexone Capsules <input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1.5 mg <input type="checkbox"/> 3.0 mg <input type="checkbox"/> 4.5 mg Sig (Please choose one): <input type="checkbox"/> Take one (1) capsule po HS <input type="checkbox"/> _____ Quantity (Please choose one): <input type="checkbox"/> [#30] <input type="checkbox"/> _____ Refills: 1 2 3 4 5 PRN NONE	<input type="checkbox"/> Compound Naltrexone 1mg Suppository <input type="checkbox"/> Vaginal <input type="checkbox"/> Rectal Sig: Insert 1 suppository QHS Quantity (Please choose one): <input type="checkbox"/> [#30] <input type="checkbox"/> _____ Refills: 1 2 3 4 5 PRN NONE
<input type="checkbox"/> Compound Naltrexone 0.5% in Lidocaine 2.5%/Prilocaine 2.5% Cream Sig: Apply 1-2 ml to painful areas once or twice daily. Quantity (Please choose one): <input type="checkbox"/> [120 ml] <input type="checkbox"/> _____ Refills: 1 2 3 4 5 PRN NONE	<input type="checkbox"/> Compound Naltrexone 1mg/ml Suspension in Mucolox Sig: Swish 1ml qd Quantity (Please choose one): <input type="checkbox"/> [30ml] <input type="checkbox"/> _____ Refills: 1 2 3 4 5 PRN NONE
<input type="checkbox"/> Compound Naltrexone 1% Cream in Lipoderm Sig: Apply up to 1 ml 2-3 times daily Quantity (Please choose one): <input type="checkbox"/> [60 ml] <input type="checkbox"/> _____ Refills: 1 2 3 4 5 PRN NONE	<input type="checkbox"/> Custom Formulation Quantity: <input type="checkbox"/> _____ Refills: 1 2 3 4 5 PRN NONE

Prescriber Signature _____

Prescriber Name _____

Phone _____ NPI # _____ DEA # _____

Address _____ DPS# _____

Please use PCAB Accredited Sterile Pharmacy

