ANESTHETIC THERAPY

Prescriber:		Patient:	D.O.B.:
Address:		Mobile Phone:	Home Phone:
City:	State: Zip:	Address:	
Phone:	Fax:	City:	State: Zip:
NPI:	DEA:	Allergies:	

BLT CREAM/GEL | BENZOCAINE, LIDOCAINE, TETRACAINE

Choose Strength and Base:	Choose Qty (gm):	SIG: Patient Instructions:	Refills: (select one)
☐ **20/6/4%** in Emollient Cream 30 days BUD	☐ 30 ☐ 60	☐ Apply as directed 30 minutes prior to procedure ☐ Apply as directed per provided instructions	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12
☐ **20/6/4%** in Lipoderm™ Cream 180 days BUD			
☐ **20/6/4%** in PLO Gel 30 days BUD			
☐ **20/6/4%** in Versa Pro 120 days BUD			
☐ **20/10/4%** in Lipoderm™ Cream 30 days BUD			
☐ **20/10/4%** in PLO Gel 30 days BUD			

Warnings:	Custom SIG:	Custom Formula:

PRESCRIBER:

Signature:_____ Date: _____ _____ _____

Fax to the Pharmacy at 888-560-6691 or 940-382-2694.