MEN'S HEALTH

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

Use the space below to write in the controlled substance that you need to order			Choose Qty:	Refills:
☐	_____ **Cream**	☐ 100 mg/gm	☐ 30	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯
	SIG: Apply_____gm(s) topically every day.	☐ 200 mg/gm	☐ 90	

☐ **Sildenafil (MC) Capsules**	36 mg ◯	75 mg ◯		
☐ **Sildenafil Troche**	50 mg ◯	100mg ◯		
☐ **Tadalafil (MC) Capsules**	7 mg ◯	12 mg ◯	17 mg ◯	25 mg ◯
☐ **Tadalafil Troche**	10 mg ◯	20 mg ◯		
☐ **Oxytocin / Tadalafil (MC) Capsules**	25 IU/ 7mg ◯		50 IU/ 12mg ◯	

Take one by mouth
☐ QDAY
☐ PRN
☐ Other:

Choose Qty:
☐ 30
☐ 90
Refills:
1 ◯ 2 ◯ 3 ◯ 4 ◯
5 ◯ 6 ◯ 7 ◯ 8 ◯
9 ◯ 10 ◯ 11 ◯ 12 ◯

Custom Formula:

PRESCRIBER:

Signature:_____ Date: ☐☐☐

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