

NEW PRESCRIPTION ORDER FORM

1 Patient Information

Last Name		First Name		MI
Address				Apt. #
City	State	ZIP	Phone Number	
Date of Birth (mm/dd/yyyy)		Sex	<input type="radio"/> M <input type="radio"/> F	Email

2 Prescriber and Prescription Information

Prescriber's Name		
Phone Number		Fax Number
Street Address		
City	State	ZIP
NPI	DEA	



Commonly Requested Formulas for Patients with Biofilms

Nasal Spray

- Gentamicin 0.008%/Mupirocin 0.2%/Edetate Disodium 0.1% Nasal Spray

Nasal Irrigation

- Mupirocin 30 mg/Edetate Disodium 15 mg/Gentamicin 80 mg Capsules (XyliFos™/LoxaSpense™)

Oral Rinse

- Azithromycin 1% Biofilm Oral Rinse
 Metronidazole 1% Biofilm Oral Rinse

Directions:

QTY: _____

Refills: 1 2 3 4 5 6 7 8 9 10 Other: _____

X _____
Prescriber's Signature Date

3 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

Pharmacy Name

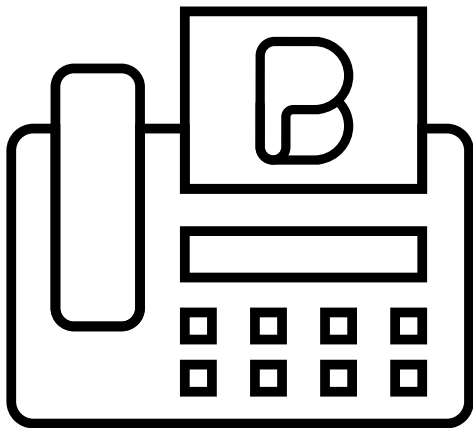
Pharmacy Fax Number

The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10



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FAX COVER SHEET



Please fax your order to:

401-284-4506

3844 Post Road, Warwick RI 02886

Phone: 401 - 284 - 4505

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