NEW PRESCRIPTION ORDER FORM – ED INJECTIONS

1 Patient Information

Last Name	First Name	MI
Address		Apt. #
City	State / ZIP / Phone Number	
Date of Birth (mm/dd/yyyy)	Sex ○ M ○ F	Email

2 Prescriber and Prescription Information

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

BI-MIX

- ○ Papaverine 30mg/ Phentolamine 1mg/ml (**Green**)
- ○ Papaverine 30mg/Phentolamine 2mg/ml (**Gold**)

ATROPINE TRI-MIX

- ○ Atropine/Papaverine/Phentolamine 0.15-20mg-2mg/ml

ALPROSTADIL

- ○ Alprostadil 20mcg/ml (**Black**)
- ○ Alprostadil 40mcg/ml

TRI-MIX

- ○ Alprostadil/Papaverine/Phentolamine 5mcg-30mg-1mg/ml
- ○ Alprostadil/Papaverine/Phentolamine 10mcg-30mg-1mg/ml (**Blue**)
- ○ Alprostadil/Papaverine/Phentolamine 20mcg-30mg-1mg/ml (**Silver**)
- ○ Alprostadil/Papaverine/Phentolamine 20mcg-30mg-2mg/ml (**Red**)
- ○ Alprostadil /Papaverine /Phentolamine 30mcg-30mg-1mg/ml
- ○ Alprostadil/Papaverine/Phentolamine 30mcg-30mg-2mg/ml
- ○ Alprostadil/Papaverine/Phentolamine 40mcg-30mg-1mg/ml
- ○ Alprostadil/Papaverine/Phentolamine 40mcg-30mg-2mg/ml

QUAD-MIX

- ○ Alprostadil/Atropine/Papaverine/Phentolamine 20mcg-0.15-30mg-2mg/ml
- ○ Alprostadil/Atropine/Papaverine/Phentolamine 30mcg-0.15-30mg-2mg/ml
- ○ Alprostadil/Atropine/Papaverine/Phentolamine 40mcg-0.15-30mg-2mg/ml

SYRINGES (#10 each)

29 gauge

- ○ 0.5ml x ½ "
- ○ 1ml x ½ "

30 gauge

- ○ 0.5ml x 5/16"
- ○ 1ml x 5/16"
- ○ 0.5ml x ½ "
- ○ 1ml x ½ "

VIAL SIZE

- ○ 1ml MDV
- ○ 2.5ml MDV
- ○ 5ml MDV

DISPENSING INSTRUCTIONS

- ○ Inject _____ ml. If not desired result, dose may be increased in increments of _____ ml not to exceed _____ ml.
- ○ Dose to be administered ___ times/week
- ○ Dose to be administered ___ times/day, No more than _____ times/week.
- ○ Other _____

Refills: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 ○ 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

Form MM-02.1

NEW PRESCRIPTION ORDER FORM – ED URETHRAL GELS

1 Patient Information

Last Name	First Name	MI
Address		Apt. #
City	State	ZIP	Phone Number
Date of Birth (mm/dd/yyyy)	Sex ○ M ○ F	Email

2 Prescriber and Prescription Information

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

BI-MIX URETHRAL GEL (per 0.25ml)

- ○ Papaverine 7.5mg/ Phentolamine 1mg/ml (per 0.25ml)
- ○ Papaverine 7.5mg/Phentolamine 2mg/ml (per 0.25ml)
- ○ Other _____

TRIPLE P URETHRAL GEL (per 0.25ml)

- ○ Alprostadil/Papaverine/Phentolamine 250mcg-7.5mg-1mg/ml
- ○ Alprostadil/Papaverine/Phentolamine 500mcg-7.5mg-1mg/ml
- ○ Alprostadil/Papaverine/Phentolamine 750mcg-7.5mg-1mg/ml
- ○ Alprostadil/Papaverine/Phentolamine 1000mcg-7.5mg-1mg/ml
- ○ Other _____

SAMPLE PACKS

- ○ Sample Pack 1
  - (**2**) TRIPLE P 250
  - (**2**) TRIPLE P 500
- ○ Sample Pack 2
  - (**2**) TRIPLE P 750
  - (**2**) TRIPLE P 1000
- ○ Custom Sample
  - ____ TRIPLE P 250
  - ____ TRIPLE P 500
  - ____ TRIPLE P 750
  - ____ TRIPLE P 1000

minimum 2 per strength

Directions: ○ Administer single dose into opening of penis once daily and no more than three times a week as directed.

○ Other _____

QTY _____ **Refills** 1 2 3 4 5 6 7 8 9 10 11 12 (circle one)

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

Form MM-03.1