

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		
<input type="radio"/> Patient will pick up at pharmacy			<input type="radio"/> Please ship to patient			<input type="radio"/> Please ship to office		

2 Prescriber and Prescription Information

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

Prescribing Form – Women's Health (2 of 4)

Vaginal Procedure Anesthetic

(Commonly requested for Mona Lisa Touch™)

☐ **Lidocaine/Tetracaine 23–7% Vaginal Cream**

☐ To be applied topically by practitioner before procedure

☐ Other _____

QTY: ☐ 30gm ☐ 45gm ☐ 60gm

Vaginal Itching

☐ **Naltrexone HCl 1% Vaginal Cream**

☐ **Ketotifen/Naltrexone HCl 0.05–1% Vaginal Cream**

☐ Apply/Insert 1gm intravaginally 2–3 times daily as needed

☐ Other _____

QTY: ☐ 30gm ☐ 45gm ☐ 60gm

Vulvar Lichen Sclerosis

☐ **Clobetasol Propionate 0.05% Anhydrous Vaginal Cream (Ellage™)**

☐ **Tacrolimus 0.03% Anhydrous Vaginal Cream (Ellage™)**

☐ **Ketotifen/Naltrexone/Tacrolimus 0.05%–0.5%–0.03% Anhydrous Vaginal Cream (Ellage™)**

☐ Apply to the affected area(s) twice daily

☐ Other _____

QTY: ☐ 30gm ☐ 45gm ☐ 60gm

Libido/Sexual Dysfunction (Scream Cream)

☐ **Arginine/Theophylline 6–2.5% Vaginal cream 30gm**

☐ **Arginine/Theophylline/Sildenafil 6–2.5–2% Vaginal Cream 30gm**

☐ Apply 0.5ml (1 pump) to clitoris 15–30 minutes prior to intercourse.

☐ Other _____

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

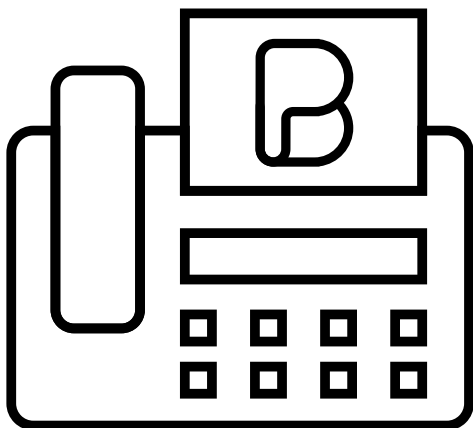
Pharmacy Fax Number

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



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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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