Date: _____ Patient Name: _____
DOB: _____**Address:** _____
City: _____State: _____ Phone: _____ Allergies: _____
□ Call When Ready □ Text Message When Ready □ Delivery □ Mail Out

□ Sumatriptan 4%/Meloxicam 2%/Topiramate 5% Topical Lipoderm® Cream
(circle one) Qty: #30 gm, 60 gm, 120 gm or: _____
Sig: _____

□ Sumatriptan 5%/Tramadol HCl 5%/Gabapentin 5%/Doxepin HCl 5%/Indomethacin 5% Topical Lipoderm® Cream
(circle one) Qty: #30 gm, 60 gm, 120 gm or: _____
Sig: _____

□ Baclofen 2%/Ketoprofen 10%/Lidocaine 5%/Gabapentin 5% Topical Lipoderm® Cream
(circle one) Qty: #30 gm, 60 gm, 120 gm or: _____
Sig: _____

□ Indomethacin 10% Topical Lipoderm® Cream
(circle one) Qty: #30 gm, 60 gm, 120 gm or: _____
Sig:
_____

□ Diclofenac Sodium 4% Topical Lipoderm® Cream
(circle one) Qty: #30 gm, 60 gm, 120 gm or: _____
Sig: _____

□ Magnesium Sulfate Heptahydrate 10% Topical Lipoderm® ActiveMax™ Cream
(circle one) Qty: #30 gm, 60 gm, 120 gm or: _____
Sig: _____

_____ **Refills: 1 2 3 4 5 PRN**

Healthcare Provider Signature:
Print Name: _____ **Agent sending**: _____
NPI: _____ **DEA**: _____

Clinic Name: _____
Clinic Address: _____
Clinic Phone/Fax: _____