



Date: _____ Patient Name: _____

DOB: _____ Address: _____

City: _____ State: _____ Phone: _____ Allergies: _____

Call When Ready Text Message When Ready Delivery Mail Out

Betamethasone Valerate 0.1%/Tranilast 1% Topical Gel (Pracasil™-Plus)

(circle one) Qty: #30gm, #240gm, or: other _____

Sig: AAA 1-2 times daily as directed for up to 10 days.

or: _____

Betamethasone Valerate 0.5% Topical Gel (Pracasil™-Plus)

(circle one) Qty: #30gm, #240gm, or: other _____

Sig: AAA 1-2 times daily as directed for up to 10 days.

or: _____

Refills: 1 2 3 4 5 PRN

Healthcare Provider Signature:

Print Name: _____ Agent sending: _____

NPI: _____ DEA: _____

Clinic Name: _____

Clinic Address: _____

Clinic Phone/Fax: _____

