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

☐ Cyanocobalamin 0.07% Topical Cream (XemaTop™)
(circle one) Qty: #30 gm**,** #60gm, #120gm or: _____
Sig: AAA topically 1-2 times daily as directed
or_____

☐ Cyanocobalamin 0.07%/Urea 2% Topical Cream (XemaTop™)
(circle one) Qty: #30 gm**,** #60gm, #120gm or: _____
Sig: AAA topically 1-2 times daily as directed
or_____

☐ Cyanocobalamin 0.07% Topical Gel (PracaSil™-Plus)
(circle one) Qty: #30 gm**,** #60gm, #120gm or: _____
Sig: AAA topically 1-2 times daily as directed
or_____

☐ Zinc Pyrithione 0.2%/Clobetasol Propionate 0.05%/Cyanocobalamin 0.07% Topical Cream (XemaTop™)
(circle one) Qty: #30 gm**,** #60gm, #120gm or: _____
Sig: AAA topically 1-2 times daily as directed
or_____

☐ Zinc Pyrithione 0.2%/Clobetasol Propionate 0.05%/Cyanocobalamin 0.07% Topical Gel (Spira-Wash™/PracaSil™-Plus)
(circle one) Qty: #30 gm**,** #60gm, #120gm or: _____
Sig: AAA topically 1-2 times daily as directed
or_____

☐ Naltrexone HCl 0.5%/Diphenhydramine HCl 2%/Vitamin D3 5000 IU/gm Topical Cream (XemaTop™)
(circle one) Qty: #30 gm**,** #60gm, #120gm or: _____
Sig: AAA topically 1-2 times daily as directed
or_____

_____ **Refills: 1 2 3 4 5 PRN**
Healthcare Provider Signature:
Print Name: _____ **Agent sending**: _____
NPI: _____ **DEA**: _____

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