



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

Ketamine HCl 5%/Gabapentin 10%/Clonidine HCl 0.2%/Baclofen 2% in Lipoderm® Cream
 (circle one) Qty: #30gm, #240gm, or: other _____
 Sig: AAA 3-4 times daily as directed
 or: _____

Flurbiprofen 10%/Cyclobenzaprine HCl 1%/Gabapentin 6%/Lidocaine 2%/Prilocaine HCl 2% in Lipoderm® Cream
 (circle one) Qty: #30gm, #240gm, or: other _____
 Sig: AAA 3-4 times daily as directed
 or: _____

Diclofenac Sodium 5%/Gabapentin 5%/Amitriptyline HCl 2% in Lipoderm® ActiveMax™ Cream
 (circle one) Qty: #30gm, #240gm, or: other _____
 Sig: AAA 3-4 times daily as directed
 or: _____

Ketamine HCl 5%/Gabapentin 6%/Amitriptyline HCl 3%/Indomethacin 5%/Tizanidine HCl 0.2%/Lidocaine 2% in Lipoderm® ActiveMax™ Cream
 (circle one) Qty: #30gm, #240gm, or: other _____
 Sig: AAA 3-4 times daily as directed
 or: _____

Ketamine HCl 10%/Baclofen 2%/Cyclobenzaprine 2%/Gabapentin 6%/Lidocaine 5% in Lipoderm® ActiveMax™ Cream
 (circle one) Qty: #30gm, #240gm, or: other _____
 Sig: AAA 3-4 times daily as directed
 or: _____

Ketamine HCl 10%/Diclofenac Sodium 8%/Gabapentin 6%/Bupivacaine HCl 1%/Cyclobenzaprine HCl 2%/Baclofen 2% in Lipoderm® ActiveMax™ Cream
 (circle one) Qty: #30gm, #240gm, or: other _____
 Sig: AAA 3-4 times daily as directed
 or: _____

CUSTOMIZE THE MEDICATIONS AND STRENGTHS

Drug	Strength Range	Desired %
<input type="checkbox"/> Amitriptyline HCl	10-20%	
<input type="checkbox"/> Baclofen	2-5%	
<input type="checkbox"/> Capsaicin	0.025-0.1%	
<input type="checkbox"/> Clonidine HCl	0.1-0.3%	
<input type="checkbox"/> Cyclobenzaprine HCl	1-4%	
<input type="checkbox"/> Diclofenac Na	2-10%	
<input type="checkbox"/> Gabapentin	6-10%	
<input type="checkbox"/> Ibuprofen	10-30%	
<input type="checkbox"/> Ketamine HCl	0.5-15%	
<input type="checkbox"/> Ketoprofen	5-20%	
<input type="checkbox"/> Lidocaine	1-10%	
<input type="checkbox"/> Pentoxifylline	5-10%	
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		

(Medications will be prepared with Lipoderm® Cream or Lipoderm® ActiveMax™ Cream if total % of active ingredients is >25%)

(circle one) Qty: 30gm, 60gm, 120gm, 240gm, 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: _____

