



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

<p><input type="checkbox"/> <b>Flurbiprofen 10%/Cyclobenzaprine HCl 1%/Gabapentin 6%/Lidocaine 2%/Prilocaine HCl 2% in Lipoderm® Cream</b>  <i>(circle one)</i> Qty: #30gm, #240gm, or: other _____        Sig: AAA 3-4 times daily as directed        or: _____</p> <p><input type="checkbox"/> <b>Ketamine HCl 10%/Baclofen 2%/Cyclobenzaprine 2%/Gabapentin 6%/Lidocaine 5% in Lipoderm® ActiveMax™ Cream</b>  <i>(circle one)</i> Qty: #30gm, #240gm, or: other _____        Sig: AAA 3-4 times daily as directed        or: _____</p> <p><input type="checkbox"/> <b>Ketamine HCl 10%/Diclofenac Sodium 8%/Gabapentin 6%/Bupivacaine HCl 1%/Cyclobenzaprine HCl 2%/Baclofen 2% in Lipoderm® ActiveMax™ Cream</b>  <i>(circle one)</i> Qty: #30gm, #240gm, or: other _____        Sig: AAA 3-4 times daily as directed        or: _____</p> <p><input type="checkbox"/> <b>Baclofen 2%/Ketoprofen 10%/Lidocaine 5%/Gabapentin 5% in Lipoderm® Cream</b>  <i>(circle one)</i> Qty: #30gm, #240gm, or: other _____        Sig: AAA 3-4 times daily as directed        or: _____</p>	<p><input type="checkbox"/> <b>Amitriptyline HCl 2%/Ketoprofen 2%/Carbamazepine 2% in Lipoderm® Cream</b>  <i>(circle one)</i> Qty: #30gm, #240gm, or: other _____        Sig: AAA 3-4 times daily as directed        or: _____</p> <p><input type="checkbox"/> <b>Tramadol HCl 5%/Lidocaine 5%/Cyclobenzaprine HCl 2%/Diclofenac Sodium 5%/ Menthol 1%/DMSO 5% in Lipoderm® ActiveMax™ Cream</b>  <i>(circle one)</i> Qty: #30gm, #240gm, or: other _____        Sig: AAA 3-4 times daily as directed        or: _____</p> <p><input type="checkbox"/> <b>Ketoprofen 10%/Ibuprofen 10%/Lidocaine 5%/Piroxicam 2%/Cyclobenzaprine HCl 2% in Lipoderm® ActiveMax™ Cream</b>  <i>(circle one)</i> Qty: #30gm, #240gm, or: other _____        Sig: AAA 3-4 times daily as directed        or: _____</p> <p><input type="checkbox"/> <b>Ibuprofen 20%/Piroxicam 1%/Cyclobenzaprine HCl 1% in Lipoderm® Cream</b>  <i>(circle one)</i> Qty: #30gm, #240gm, or: other _____        Sig: AAA 3-4 times daily as directed        or: _____</p>
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\_\_\_\_\_  
**Healthcare Provider Signature:**  
**Print Name:** \_\_\_\_\_  
**NPI:** \_\_\_\_\_

**Refills:**    1    2    3    4    5    PRN  
**Agent sending:** \_\_\_\_\_  
**DEA:** \_\_\_\_\_

<p><b>Clinic Name:</b> _____  <b>Clinic Address:</b> _____  <b>Clinic Phone/Fax:</b> _____</p>	
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