Date: ___________ Patient Name: ____
DOB: ____________**Address: **____
City: ____________State: _____ Phone: ___________ Allergies: _______________
□ Call When Ready □ Text Message When Ready □ Delivery □ Mail Out

□ Nifedipine 4% in Topical Lipoderm® Cream
Qty: 30 gm or: _______________
Sig: AAA topically 1-2 times daily as needed.
Or: _________________________________

□ Nifedipine 8% in Topical Lipoderm® Cream
Qty: 30 gm or: _______________
Sig: AAA topically 1-2 times daily as needed.
Or: _________________________________

□ Nifedipine 16% in Topical Lipoderm® Cream
Qty: 30 gm or: _______________
Sig: AAA topically 1-2 times daily as needed.
Or: _________________________________
.

□ Pentoxifylline 5% in Topical Lipoderm® Cream
Qty: 30 gm or: _______________
Sig: AAA topically 1-2 times daily as needed.
Or: _________________________________

□ Pentoxifylline 5%/Nifedpine 2% in Topical Lipoderm® Cream
Qty: 30 gm or: _______________
Sig: AAA topically 1-2 times daily as needed.
Or: _________________________________

□ Pentoxifylline 3%/Nifedipine 3% in Topical Lipoderm® Cream
Qty: 30 gm or: _______________
Sig: AAA topically 1-2 times daily as needed.
Or: _________________________________

____
Healthcare Provider Signature:

Refills: 1 2 3 4 5 PRN

Print Name: __________________________________ **Agent sending**: ___________________________
NPI: ____ **DEA**: __________________________________

Clinic Name: _____________________________________
Clinic Address: __________________________________
Clinic Phone/Fax: ________________________________