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

□ **Ketoprofen 10% Topical Lipoderm® Cream**
(circle one) Qty: #30gm, #240gm, or other _____
Sig: AAA 3-4 times daily as needed.
Or: _____

□ **Ibuprofen 20% Topical Lipoderm® Cream**
(circle one) Qty: #30gm, #240gm, or other _____
Sig: AAA 3-4 times daily as needed.
Or: _____

□ **Glutathione 20% (W/W) Topical Lipoderm® Cream**
(circle one) Qty: #30gm, #240gm, or other _____
Sig: AAA 3-4 times daily as needed.
Or: _____

□ **Magnesium Chloride Hexahydrate 10% Topical Lipoderm® Cream**
(circle one) Qty: #30gm, #240gm, or other _____
Sig: AAA 3-4 times daily as needed.
Or: _____

□ **Naltrexone 1.5 mg Capsules**
Qty #42 caps
Sig: Take 1 capsule by mouth once daily for 2 weeks, then take 2 capsules (3 mg) once daily for 2 weeks then increase to 4.5 mg daily thereafter.

□ **Naltrexone 4.5 mg Capsules**
Qty #90 caps
Sig: Take 1 capsule by mouth once daily.
Or:_____

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

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