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

□ Ketoconazole 2%/Miconazole 2%/Clotrimazole 1% Topical Cream (VersaBase®)
Qty: 30 gm or: _____
Sig: AAA twice daily as needed.
Or: _____

□ Clotrimazole 2%/Ibuprofen 2%/Tea Tree Oil 1% Topical Cream
Qty: 30 gm or: _____
Sig: AAA twice daily as needed.
Or: _____

□ Ketoconazole 2%/Tea Tree Oil 5%/DMSO Topical Solution
Qty: 30 ml or: _____
Sig: AAA twice daily as needed.
Or: _____

□ Ketoconazole 2% Topical Foam (VersaBase®)
Qty: 30 ml or: _____
Sig: AAA twice daily as needed.
Or: _____

□ Ketoconazole 2%/Ibuprofen 2% Topical Powder
Qty: 30 gm or: _____
Sig: AAA twice daily as needed.
Or: _____

□ Amphotericin B 3% Topical Lotion
Qty: 30 ml or: _____
Sig: AAA twice daily as needed.
Or: _____

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

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