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: ____________________________________

□ Ketoprofen 10%/Cyclobenzaprine HCl 2% Topical Lipoderm® ActiveMax™ Cream
(circle one) Qty: #30gm, #240gm, or other ______
Sig: AAA 3-4 times daily as needed.
Or: ____________________________________

□ Diclofenac Sodium 10% Topical Lipoderm® ActiveMax™ Cream
(circle one) Qty: #30gm, #240gm, or other ______
Sig: AAA 3-4 times daily as needed.
Or: ____________________________________

□ Piroxicam 5% 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: ____________________________________

□ Ibuprofen 20%/Piroxicam 1% Topical Lipoderm® Cream
(circle one) Qty: #30gm, #240gm, or other ______
Sig: AAA 3-4 times 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: _______________________________