Date: ___________ **Patient Name**: ____
DOB: _____________**Address:** ____
City: _____________**State:** ______ **Phone:** ____________ **Allergies:** _________________
☐ **Call When Ready** ☐ **Text Message When Ready** ☐ **Delivery** ☐ **Mail Out**

☐ **Lidocaine HCl 1%/Diphenhydramine HCl 2%/Dexamethasone 0.5%/Cimetidine 4% Topical Cream (VersBase®)**
(circle one) Qty: #30gm, #120gm, #240gm, or ______
Sig: AAA 2-4 times daily as needed.
Or: ____

☐ **Hydrocortisone 2.5%/Pramoxine HCl 1% Topical Cream**
(circle one) Qty: #30gm, #120gm, #240gm, or ______
Sig: AAA 2-4 times daily as needed.
Or: ____

☐ **Pitch Ointment (PracaSil®-Plus)**
(circle one) Qty: #30gm, #120gm, #240gm, or ______
Sig: AAA 2-4 times daily as needed.
Or: ____

☐ **Diphenhydramine HCl 2%/Pramoxine HCl 1%/Hydrocortisone Acetate 0.5% Topical Gel**
(circle one) Qty: #30gm, #120gm, #240gm, or ______
Sig: AAA 2-4 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: ______________________________