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

□ **Wart Magic (Salicylic Acid 20%/Lactic Acid 10%/ Formaldehyde 8% in Flexible Collodion)** Qty: 15 ml
Sig: Apply topically to warts QHS and cover

□ **Salicylic Acid 20%/5-FU 5% in DMSO** Qty: 15 ml
Sig: Apply topically to warts QHS and cover

□ **Salicylic Acid 50% in White Petrolatum** Qty: 30 gm
Sig: Apply topically to warts QHS and cover

□ **Cimetidine/Deoxy-D-Glucose/Ibuprofen 10%/0.29%/2% Cream** Qty: 30 gm
Sig: Apply topically to warts QHS

□ **Squaric Acid Dibutyl Ester 0.1% Topical Solution**
Qty: 15 ml
Sig: Apply topically to warts QHS

□ **Dinitrochlorobenzene Ointment**
(circle strength) 1% or 2% Qty: 30 gm
Sig: Apply topically to warts QHS and cover

□ **Diphenylcyclopropenone 0.01% Topical Solution**
Qty: 25 ml
Sig: Apply topically as directed

□ **Cantharadin** Qty: _____
Sig: Apply topically as directed

□ **Cantharadin Plus** Qty: _____
Sig: Apply topically as directed

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

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