Date: _____ **Patient Name**: _____
DOB: _____ **Address:** _____
City: _____ **State:** ____ **Zip:** _____ **Phone:** _____ **Allergies:** _____
☐ **Call When Ready** ☐ **Text Message When Ready** ☐ **Mail Out**

☐ **Testosterone in Versabase Topical Cream**
***(circle strength)* 1% or 2%**
Qty: 9 ml
Sig: Apply 0.1-0.3 ml once daily in the AM. Start at 0.1 ml daily for 2 weeks, then 0.2 ml for 2 weeks, then 0.3 ml daily if tolerated well.

☐ **Libido #1 Theophylline 2.6%/Arginine(L) 6%/Sildenafil 1% Cream**
Qty: # 10 ml
Sig: Apply a pea-sized amount topically to clitoral area 5-30 min prior to intercourse as directed.

☐ **Libido #2 Theophylline 2.6%/Arginine(L) 6%/Menthol 0.025%/Nifedipine 0.2% Cream**
Qty: # 10 ml
Sig: Apply a pea-sized amount topically to clitoral area 5-30 min prior to intercourse as directed.

☐ **Oxytocin 120 U/gm Vaginal Gel (Mucolox™/Versabase®)**
Qty: # 45 gm
Sig: Apply a pea-sized amount topically to clitoral area 5-30 min prior to intercourse as directed.

☐ **Oxytocin Nasal Spray 6 units per actuation**
Qty: # 15 ml - Each spray delivers 0.1 ml (6 Units)
Sig: Instill 2 sprays in each nostril as needed

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

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