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

☐ **Ketamine 4%/Ketoprofen 10%/Lidocaine 2% Cream**
*(circle one)* Qty: #30gm, #120gm, #240gm, or ______
Sig: AAA 3-4 times daily as needed.
Or: ________________________________________

☐ **Ketamine 5%/Gabapentin 10%/Clonidine 0.2%/ Baclofen 2% Cream**
*(circle one)* Qty: #30gm, #120gm #240gm, or ______
Sig: AAA 3-4 times daily as needed.
Or: ________________________________________

☐ **Dexamethasone 0.4%/Ketamine 1%/Ketoprofen 15%/Lidocaine 5% Cream**
*(circle one)* Qty: #30gm, #120gm, #240gm, or ______
Sig: AAA 3-4 times daily as needed.
Or: ________________________________________

☐ **Dexamethasone 0.4%/Ketamine 3%/Ketoprofen 15%/Lidocaine 5%** *(circle one)*
*(circle one)* Qty: #30gm, #120 gm, #240gm, or ______
Sig: AAA 3-4 times daily as needed.
Or: ________________________________________

☐ **Dexamethasone 0.4%/Ketamine 5%/Ketoprofen 15%/Lidocaine 5% Cream**
*(circle one)* Qty: #30gm, #120 gm, #240gm, or ______
Sig: AAA 3-4 times daily as needed.
Or: ________________________________________

☐ **Clonidine 0.2%/Gabapentin 6%/Ketamine 10% Cream**
*(circle one)* Qty: #30gm, #120 gm, #240gm, or ______
Sig: AAA 3-4 times daily as needed.
Or: ________________________________________

☐ **Amitriptyline 2%/Gabapentin 6%/Ketamine 8%/Lidocaine 2% Cream**
*(circle one)* Qty: #30gm, #120 gm, #240gm, or ______
Sig: AAA 3-4 times daily as needed.
Or: ________________________________________

| Drug | Strength Range | Desired % |
|---|---|---|
| ☐ **Amitriptyline** | **1-2%** | ____________ |
| ☐ **Baclofen** | **2-5%** | ____________ |
| ☐ **Capsicin** | **0.025-0.1%** | ____________ |
| ☐ **Clonidine** | **0.1-0.3%** | ____________ |
| ☐ **Cyclobenzaprine** | **1-4%** | ____________ |
| ☐ **Dexamethasone** | **0.4-0.5%** | ____________ |
| ☐ **Diclofenac Na** | **2-10%** | ____________ |
| ☐ **Gabapentin** | **6-10%** | ____________ |
| ☐ **Ibuprofen** | **10-30%** | ____________ |
| ☐ **Ketamine** | **0.5-15%** | ____________ |
| ☐ **Ketoprofen** | **5-20%** | ____________ |
| ☐ **Lidocaine** | **1-10%** | ____________ |
| ☐ **Pentoxifylline** | **5-10%** | ____________ |

Qty: 30gm, 60gm, 120gm, 240gm, or other ________
Sig: AAA 3-4 times daily as needed.
Or: ________________________________________

☐ **Naltrexone 1.5 mg Capsules** Qty #42
Sig: Take 1 capsule by mouth once daily for 2 weeks, then take 2 capsules (3 mg) once daily for 2 weeks then increase to 4.5 mg daily thereafter.

☐ **Naltrexone 4.5 mg Capsules** Qty #90
Sig: Take 1 capsule by mouth once daily.
Alternative Sig: ________________________________

________________________________________ **Refills: 1 2 3 4 5 PRN**
***Healthcare Provider Signature:***
**Print Name**: ____________________________________ **Agent sending**: ____________________________
**NPI**: ____________________________________________ **DEA**: ____________________________________

**Clinic Name:** ________________________________
**Clinic Address:** ______________________________
**Clinic Phone/Fax:** ____________________________