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

☐ **Deoxy-D-Glucose 0.2%/Acyclovir 5%/Imiquimod 2.5%/Tea Tree Oil 2.5% Gel (MucoLox™/VersaBase®)**
(circle one) Qty: #30gm, #90 gm, #240gm, or: other_________
Sig: AAA 1-2 times daily as directed
or: ____

☐ **Fluorouracil (5-FU) 5% Topical Gel (MucoLox™/VersaBase®)**
(circle one) Qty: #30gm, #90 gm, #240gm, or: other_________
Sig: AAA 1-2 times daily as directed
or: ____

☐ **Fluorouracil (5-FU) 5% Topical Gel (MucoLox™/PracaSil™-Plus)**
(circle one) Qty: #30gm, #90 gm, #240gm, or: other_________
Sig: AAA 1-2 times daily as directed
or: ____

☐ **Imiquimod 0.5% Gel (MucoLox™/VersaBase®)**
(circle one) Qty: #30gm, #90 gm, #240gm, or: other_________
Sig: AAA 1-2 times daily as directed
or: ____

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

Clinic Name: ____
Clinic Address: ____
Clinic Phone/Fax: ______________________________________