

FOR FAX PRESCRIPTIONS ONLY

State License # _____

DEA # _____

RSF-TS

RX ORDER FORM - Cash or Credit Card Patient

1 Patient's Name _____ Phone # _____

D.O.B. _____ Allergies _____

Patient Shipping Address _____
We only ship to U.S. physical mailing addresses no P.O. Boxes.

Patient Billing Address (check if same) _____

Patient Email **required* (Please send the receipt to the following e-mail address) _____

CC#: (circle) MC VS AMEX DC _____ Exp. _____ Security Code _____

Diagnosis _____

2 Please include a Universal Claim Form for insurance records or reimbursement.

3 **RX – Controlled Substances** – Please write in the patient's prescription order below. All controlled substance orders must be faxed directly from the M.D.'s office to Compounding Pharmacy or written on state approved security form.

DRUG NAME	QTY	SIG	REFILL

Controlled substance compound options; do NOT check below –must be hand written above.

Fibro Freez™ 30 or 60 grams
(ketamine HCL 10% / cyclobenzaprine HCL 2% / benzocaine 10% / ketoprofen 10% / doxepin HCL 5%) LDS C-III

Neurelief™ 30 or 60 grams
(gabapentin 6% / ketamine HCL 10% / lidocaine 5% / tetracaine HCL 3% / amitriptyline HCL 2%) LDS C-III

4 (Must Complete This Section) **TOTAL # OF RXs PRESCRIBED** _____ **AUTO REFILLS** _____

UPON PATIENT REQUEST, PLEASE FAX DIRECTLY FROM THE PRESCRIBER'S OFFICE TO RSF PHARMACEUTICALS AT (949) 266-8210.

I CERTIFY THAT THIS DRUG ORDER IS BEING ISSUED FOLLOWING A GOOD FAITH PRIOR EXAMINATION OF THE PATIENT AT WHICH BOTH THE PATIENT AND I WERE PRESENT.

Prescriber Signature _____ Date _____