

PRESCRIPTION ORDER

Account #

*Email tracking to:

Account Open Date

Bill to Patient

Clinic/ Physician name:

Phone:

Address:

City:

ST:

Zip:

MUST CHECK ONE

Ground

2nd Day

Overnight

PATIENT INFORMATION

Name:

DOB:

Address:

City:

State:

Zip:

Phone:

Email

MUST CHECK ONE:

Patient will pick-up at pharmacy

Ship to patient address

Ship to office address

503B Label	Papaverine mg/ml	Phent. mg/ml	PGE mcg/ml	Atropine mg/ml
PGE2			80	
FormF1	1.8	0.2	18	.02
FormF9	0.9	0.1	20	.01
BM3	30	3		
T-50	8	0.29	2.9	
NB-243	30	3	20	
NB-343	30	3	30	
T-101	17.65	0.59	5.9	
T-105	30	1	10	
T-106	30	1	25	
SB4	30	3	40	
SB5	30	3	50	
SB6	30	3	60	
ST2	30	3	100	
RE1	30	3	200	
RE2	30	3	300	
FA	20	2	20	0.2
QM2	30	3	60	0.2
QM3	30	3	150	0.2
QM4	30	3	300	0.2
ST#1	30	1.5	50	
AT#6	40	4	0	0.3

"Reversal Medication" in case of priapism
Include Phenylephrine 1mg/ml 5ml



Revised 5-30-2025

Dispense Qty: 2.5ml

5ml

10ml

of syringes / bags of 10 2 / 1cc | 30 gauge | 1/2" | alcohol swabs

Autoject II

Sig:

Physician Name (Print):

Physician Signature:

Date:

NPI:

Phone:

Refills: