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		
☐ 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	
☐ 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	

"Reversal Medication" in case of priapism

☐ Include Phenylephrine 1mg/ml 5ml

Revised 7-15-2025

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: