Return by fax to Woodman Pharmacy: 937-254-3315

Patient		DOB
Contact Phone	Email	
Address		
City	State	Zip
Allergies	Diagnosis	
Is this a worker's comp. claim? Y N		

Prescriber (required)		
Person Faxing Form (required)		
DEA	NPI	
Address		
City	State	Zip
Phone	Fax	

*Information does not need to be repeated if already on file

PLEASE FAX CURRENT PATIENT INSURANCE & HEALTH INFORMATION

PLEASE MARK THROUGH ANY UNWANTED MEDICATIONS FROM THE FORMULATIONS BELOW

☐Note: All Formulations contain Pentoxifylline 3%, please check box to remove

Neuropathic Pain

☐ **1.) General Neuropathies /Sympathetic Component**

Bupivacaine	1%
Clonidine	0.2%
Doxepin	5%
Gabapentin	6%

☐ **2.) General Neuralgias/ Post Herpetic Neuralgias**

Bupivacaine	1%
Carbamazepine	3%
Doxepin	3%
Gabapentin	6%
Topiramate	1%

☐ **3.) Peripheral Neuropathies**

Bupivacaine	1%
Doxepin	3%
Gabapentin	6%
Nifedipine	2%
Topiramate	1%

☐ **4.) General Neuropathies**

Amantadine	8%
Bupivacaine	1%
Diltiazem	2%
Doxepin	3%
Gabapentin	6%
Orphenadrine	5%
Topiramate	2%

Anti-Inflammatory

☐ **5.) General Joint & Musculoskeletal Pain, Plantar Fasciitis, Osteoarthritis, Tendonitis**

Diclofenac	3%
Baclofen	2%
Bupivacaine	1%
Gabapentin	6%
Ibuprofen	3%

Combination

☐ **6.) Myofascial Pain Syndromes**

Baclofen	2%
Bupivacaine	1%
Cyclobenzaprine	2%
Gabapentin	6%
Orphenadrine	5%

☐ **7.) Neuropathic Pain W/ Large Inflammatory Component**

Bupivacaine	1%
Diclofenac	3%
Doxepin	3%
Gabapentin	6%
Orphenadrne	5%

☐ **8.) Herpetic Antiviral Cream (Active)**

Bupivacaine	1%
Doxepin	3%
Gabapentin	6%
Ketorolac	0.5%
Acyclovir	5%

☐ Lidocaine-Prilocaine 2.5%, Diclofenac 4%, Gabapentin 6%

☐ Other formulation or specific considerations ____________________

PLEASE CHECK BOXES BELOW IF YOU LIKE TO ADD ANY OF THE FOLLOWING TO THE FORMULATION:

☐ Carbamazepine 3% ☐ Diclofenac 3% ☐ Topiramate 1% ☐ Verapamil 6%

☐ Cimetidine 3% ☐ Orphenadrine 5% ☐ Ketoprofen 10% ☐ ____________ (Other Medication) ☐ ____________ (Other Medication)

SIG Apply 1-2 GM to affected area 3-4 times daily.

ALT SIG ☐ ____________________

Quantity: 30 Day Supply

☐ 90 GM ☐ 180 GM

☐ 120 GM ☐ 240 GM

Other ____________

*Unless specified, 120gm will be filled

Refills ____________

Prescriber Signature: ____________________ **Date:** ____________

This prescription authorized through ____________________ (Name of Physician) MD/DO by ____________________ (Name of Physician's Assistant/NP) PA/NP

FOR PHYSICIAN USE ONLY — This Prescription Pad contains formulations developed in conjunction with physicians and used in the treatment of the listed associates medical conditions. The exact formulation may be modified in accordance with the professional clinical judgment of the physician in consultation with the patient.