YOUR HEALTH PHARMACY

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Urology Prescription Form (Part 2)

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____
Allergies: □ NKDA (no known drug allergies) □ Aspirin/ NSAID's □ Cyclobenzaprine □ Lidocaine / Local Anesthetic □ Tramadol □ Opioid
□ Gabapentin □ Penicillin □ Amitriptyline □ Other:_____

"LOW T" Treatment Options

Note: The law requires prescribers to hand write Controlled Substances Rx's

□ **Medication:**_____**mg/ml Topical**
(circle) Cream Atrevis Gel

SIG: Apply _____

Dispense:_____ml Refills:_____

□ **Medication:**_____**Cypionate**
100mg/ml OR 200 mg/ml(Select one Strength) Injection (commercial)

SIG: Inject _____

Dispense:_____ml Refills:_____

□ **Medication:**_____**SL Troche**
(circle) 1 mg 2 mg 4 mg
_____mgSIG: ½ or 1 troche SL QD
Qty:_____ Refills: # _____

□ **Medication:**_____100 mg / Tadalafil 40 mg
SL Troche
SIG: ½ troche SL 30- 60 minutes prior to sexual activity
#_____Refills: #_____

Peyronie's Disease Treatments

Verapamil 15% / Triamcinolone 1% Lipoderm topical

SIG: Apply BID As Directed

Qty:_____grams

Refills: #_____or PRN

□ **DHEA SR Capsules #30**
(circle) 5 mg 10 mg 25 mg 50 mg 100 mg

SIG: 1 capsule PO QD
Refills: #_____or PRN

□ **Anastrazole SR Capsules #8**
(circle) 0.25 mg 0.5 mg 1 mg

SIG: 1 capsule PO twice a week
Refills: #_____or PRN

□ **Clomiphene 50 mg Tablets #60**

SIG: 1-2 tabs PO once daily
Refills: #_____or PRN

□ **Clomiphene 25 mg / Tadalafil 5 mg Capsules #30**
SIG: 1 capsule PO once daily
Refills: #_____or PRN

Other Therapy Options

□ **Oxytocin 50 IU Sublingual Tablet**

SIG: Dissolve 1 – 2 tablets
□ SL QD
□ SL one hour prior to intercourse PRN
Qty:_____tablets
Refills: #_____or PRN

□ **Cabergoline 0.5 mg Tablet**
SIG: 1 tablet po twice a week
#8
Refills: #_____or PRN

□ **HCG 1,000 IU/ml (commercial product)**
10 ml vial
#_____vials
Refills: #_____or PRN

*** (Prescriber's initials)** _____ I am prescribing these compounds because they are clinically necessary for the treatment of this patient

Physician Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
DEA: _____ NPI: _____

_____ _____
Physician's Signature Date

FDA does not review any compounded medication for safety/efficacy. CMPD refers to a compounded med.