

Get Started Today!

- Simply print out the attached Rx order form and take it to your doctor.
- Doctor to complete and sign Rx.
- Doctor to fax Rx to (877) 791-7779.
- We will ship Formula 27 Scar Gel to your home.



PH: (855) 246-6338

Hair Loss Treatment Prescription Order Form

Free Delivery!

Please Fax to:
(877) 791-7779

Prescription Order Form

Patient Information:

PLEASE FAX Patient Demographic Sheet & Prescription Insurance Card if available.

FIRST NAME:	LAST NAME:	DATE OF BIRTH:
PRIMARY PHONE #: <input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK	SECONDARY PHONE #: <input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK	LAST 4 DIGITS OF SSN:
ADDRESS:	CITY, STATE, ZIP:	ALLERGIES: (If no allergies please check the NKDA box) <input type="checkbox"/> NKDA

Rx Medication Order:

Pharmacist Please Compound:

Prescriber: You may change the directions, or delete / substitute / add any additional medications for all formulations.

Rx

Formula 27 Scar Gel

Tamoxifen citrate 0.2% QTY: 30gm/\$85 60gm/\$149

Lipoic Acid 5%
in PracaSil™-Plus scar gel SIG: Apply 1-2gm topically to scar daily.

ADD: Lidocaine 5%

Refills: _____

Formula 27-S Scar Gel

Tamoxifen citrate 0.2% QTY: 30gm/\$95 60gm/\$169

Lipoic Acid 5%
Betamethasone val 0.1%
in PracaSil™-Plus scar gel SIG: Apply 1-2gm topically to scar daily.

ADD: Lidocaine 5%

Refills: _____

Notes:

For studies on PracaSil™-Plus scar gel visit <https://elitemedicalplus.com/casestudies>

Prescriber Information:

PRESCRIBER'S SIGNATURE:

PRESCRIBER NAME (PRINT):

NPI# or DEA# (CTP# for CNPs only):

DATE:

Contact Information:

ADDRESS:

CITY:

STATE:

ZIP:

PHONE #:

FAX #:

*Aids in relieving the symptoms of these conditions and specialties.

The information provided herein is for reference only and is not to be relied upon as making any representation as to the efficacy of any particular formulations. Nothing herein is intended to replace the independent judgement of a licensed professional. This form is proprietary of BioMed Pharmacy and is only intended for use between provider and patient. Any unauthorized use could result in legal action. This facsimile transmission is intended to be delivered to the named addressee and may contain information that is confidential, privileged, and proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and/or telephone number set forth herein and obtain instructions as to the disposal of the transmitted material. In no event should such material be read or retained by anyone other than the addressee, except by express authority of the sender to the named addressee. FDA does not review compounded medication for safety or efficacy.

BMail_27Scar
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Attention Ohio Prescribers: This order form cannot be used to issue a prescription order for any Ohio resident. In lieu, you may call in a prescription by phone or submit your own form via fax.