

<b>Patient Information:</b>		<i>PLEASE FAX with Patient Demographic Sheet and State Issued Photo ID</i>	
FIRST NAME:	LAST NAME:	ADDRESS:	
DATE OF BIRTH:		CITY, STATE, ZIP:	
PRIMARY PH #:		ALLERGIES: (If no allergies please check the NKDA box) <input type="checkbox"/> NKDA	

<b>Rx Medication Order:</b>	<b>Pharmacist Please Compound:</b>	Compounded testosterone is free of any gluten, casein, dyes, sulfates and parabens. We can also eliminate the use of any ingredient the patient is allergic to.
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**Testosterone # 31 Formula** (micronized, male dosing) Please choose strength and quantity by checking the appropriate box

<b>Strength:</b> <input type="checkbox"/> 50mg (5%) (per gram of base)	<b>Quantity:</b> <input type="checkbox"/> 30gm/\$53 <input type="checkbox"/> 60gm/\$105 <input type="checkbox"/> 90gm/\$147	<b>Base:</b> <input type="checkbox"/> Cream <input type="checkbox"/> Gel (choose one base)
<input type="checkbox"/> 75mg (7.5%)	<b>Quantity:</b> <input type="checkbox"/> 30gm/\$59 <input type="checkbox"/> 60gm/\$114 <input type="checkbox"/> 90gm/\$157	<b>SIG:</b> Apply 1gm topically to upper arm or shoulder QAM
<input type="checkbox"/> 100mg (10%)	<b>Quantity:</b> <input type="checkbox"/> 30gm/\$65 <input type="checkbox"/> 60gm/\$125 <input type="checkbox"/> 90gm/\$169	
<input type="checkbox"/> 150mg (15%)	<b>Quantity:</b> <input type="checkbox"/> 30gm/\$74 <input type="checkbox"/> 60gm/\$144 <input type="checkbox"/> 90gm/\$189	
<input type="checkbox"/> Other: _____ mg    Quantity= _____ gm		<b>Refill:</b> _____

<b>Prescriber Information:</b>	
PRESCRIBER'S SIGNATURE:	
PRESCRIBER NAME (PRINT):	
DEA#	DATE:

<b>Contact Information:</b>		
ADDRESS:		
CITY:	STATE:	ZIP:
PHONE #:	FAX #:	

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 obtains 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.

**BM\_Half\_MALETEST21 040122**

**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.**