



**Absolute Wellness
Pharmacy**

ph: (818) 912-6800
fax: (818) 912-6989

PATIENT INFORMATION **BHRT ORDER FORM**

PATIENT NAME (PRINT) _____ DOB _____

ALLERGIES _____ DIAGNOSIS CODE _____

PATIENT ADDRESS _____

CITY STATE ZIP _____

HOME PHONE _____ CELL PHONE _____

INSURANCE INFORMATION

INSURANCE NAME _____ MEMBER ID _____

BIN _____ GROUP # _____ PCN # _____ HELP DESK PHONE# _____

Product	Refills
<input type="checkbox"/> Bi-Est (80/20) Crm <input type="checkbox"/> Bi-Est (50/50) Crm	<input type="checkbox"/> 2mg/ml <input type="checkbox"/> 6mg/ml <input type="checkbox"/> 4mg/ml <input type="checkbox"/> 8mg/ml <input type="checkbox"/> Apply 4 clicks (1ml) once a day Refill: _____
<input type="checkbox"/> Estradiol Crm <input type="checkbox"/> Progesterone Crm	<input type="checkbox"/> 1mg/ml <input type="checkbox"/> 3mg/ml <input type="checkbox"/> 2mg/ml <input type="checkbox"/> 4mg/ml <input type="checkbox"/> 100mg/ml <input type="checkbox"/> 200mg/ml <input type="checkbox"/> Apply 4 clicks (1ml) once a day Refill: _____
<input type="checkbox"/> Progesterone Caps	<input type="checkbox"/> 100mg <input type="checkbox"/> 200mg <input type="checkbox"/> Take 1 capsule PO at bedtime Refill: _____
<input type="checkbox"/> Progesterone SR Caps	<input type="checkbox"/> 100mg <input type="checkbox"/> 200mg <input type="checkbox"/> Take 1 capsule PO at bedtime Refill: _____
<input type="checkbox"/> Testosterone Crm	<input type="checkbox"/> 1mg/ml <input type="checkbox"/> 3mg/ml <input type="checkbox"/> 2mg/ml <input type="checkbox"/> 4mg/ml <input type="checkbox"/> Apply 4 clicks (1ml) once a day Refill: _____
<input type="checkbox"/> Bi-Est 2.5mg, Progesterone 100 mg/ml Crm	<input type="checkbox"/> Apply 4 clicks (1ml) once a day Refill: _____
<input type="checkbox"/> Bi-Est 2.5mg, Progesterone 100mg/ml, Testosterone 1mg/ml Crm	<input type="checkbox"/> Apply 4 clicks (1ml) once a day Refill: _____
<input type="checkbox"/> Estriol Vaginal Cream	<input type="checkbox"/> 0.1% <input type="checkbox"/> 0.2% <input type="checkbox"/> 0.05% <input type="checkbox"/> 0.5% <input type="checkbox"/> Take 1 applicator vaginally <input type="checkbox"/> Take 1 applicator vaginally Refill: _____
<input type="checkbox"/> Liothyronine (T3)SR Capsule	<input type="checkbox"/> 5mcg <input type="checkbox"/> 15mcg <input type="checkbox"/> 7.5mcg <input type="checkbox"/> 20mcg <input type="checkbox"/> 10mcg <input type="checkbox"/> 30mcg <input type="checkbox"/> Take 1 capsule po Qam Refill: _____
<input type="checkbox"/> Thyroid (Desiccated) Capsule	<input type="checkbox"/> 15mg <input type="checkbox"/> 90mg <input type="checkbox"/> 30mg <input type="checkbox"/> 120mg <input type="checkbox"/> 60mg <input type="checkbox"/> 180mg <input type="checkbox"/> Take 1 capsule po Qam <input type="checkbox"/> _____ Refill: _____

Physician Verification

I have reviewed my patient's medical record and determined the medication(s) / supplies ordered are medically necessary. I verify I have examined and diagnosed the patient as indicated above. I will comply with state and federal documentation requirements by retaining a copy of this prescription in the patient's medical record. The prescription is to be dispensed as written unless otherwise instructed by me.

Signature: _____ Date: _____

Physician: _____ NPI #: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Fax: _____

FAX FORM TO: (818) 912- 6989

IMPORTANT: Please fax insurance card. Your patient will be called promptly. Revision Date: 09/09/2016