Absolute Wellness Pharmacy

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MENS HEALTH ORDER FORM

Phone: (818) 912-6800 | Fax: (818)912-6989

PATIENT INFORMATION

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		QTY	REFILLS
Restoring Hormone Balance:			
☐ Testosterone 50mg/ml Cream		☐ 30gm	_____
☐ Testosterone 100mg/ml Gel		☐ 30gm	_____
☐ DHEA 20mg/ml Cream		☐ 30gm	_____
☐ Testosterone 50mg, DHEA 25mg/ml Gel		☐ 30gm	_____
☐ Testosterone 50mg, Chrysin 15mg/ml Cream		☐ 30gm	_____
	Sig: Apply 4 clicks (1mL) every day		
☐ Testosterone 100mg Troche		☐ #30	_____
	Sig: Dissolve 1 troche under gum every day		
Aromatase Inhibitors:			
☐ Anastrozole 0.1mg Capsule		☐ #30	_____
☐ Anastrozole 0.25mg Capsule		☐ #30	_____
	Sig: Take 1 capsule by mouth twice a week		
Erectile Dysfunction:			
☐ Sildenafil 50mg Troche		☐ #30	_____
☐ Sildenafil 100mg Troche		☐ #30	_____
	Sig: Dissolve 1 troche under gum 30 minutes prior to activity		
Hair Growth:			
☐ Finasteride 0.1%/Minoxidil 3% Solution		☐ 120mL	_____
	Sig: Apply to scalp every day		
☐ Other _____			

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: 10/25/2016