Q1 2025

PharmaLabs

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☐ **Bill to Patient** ☐ **Bill to Practice**

☐ **Ship to Residence** ☐ **Ship to Office**	Shipping Address: _____ _____

Patient Name:_____ Date of Birth:_____

Patient Phone:_____ Email:_____

ERECTILE DYSFUNCTION

INTRACAVERNOSAL INJECTION:

	Mixture	Papaverine (mg/mL)	Phentolamine (mg/mL)	PGE1 (mcg/mL)	Atropine (mcg/mL)
☐	**PGE1***	-	-	**25**	-
☐	**Bimix #30/2**	30	2	-	-
☐	**Bimix #3**	15	0.5	-	-
☐	**Bimix #4**	30	1	-	-
☐	**Bimix #10**	30	4	-	-
☐	**Trimix #5**	30	1	10	-
☐	**Trimix #6**	30	4	2.5	-
☐	**Trimix #7**	30	4	5	-
☐	**Trimix #8**	30	2	20	-
☐	**Trimix #9**	30	4	40	-
☐	**Trimix #11**	30	4	7.5	-
☐	**Trimix #12**	30	4	10	-
☐	**Trimix #13**	30	6	60	-
☐	**Trimix #14**	30	1	2.5	-
☐	**Trimix #15**	30	2	40	-
☐	**Trimix #16**	30	6	100	-
☐	**Quadmix 30/2/10/100**	30	2	10	100
☐	**Quadmix 30/3/40/200**	30	3	40	200

SIG: Dispense: 1 Month Supply **QTY:** 5mL **Refills:** _____
Inject _____ units intracavernosal as instructed
Increase or decrease by _____ units
Maximum Dose _____ units
May use ☐ Daily ☐ 3-4 times weekly

CHOOSE SYRINGE:
☐ 1cc: 31 gauge x 5/16" insulin syringes **QTY:** 20
☐ 1cc: 29 gauge x 1/2" insulin syringes **QTY:** 20
*PGE1 Only: ☐ By checking this box, prescriber has determined PGE1 compound is medically necessary.

RETAIL, INJECTION ACCESSORIES, SUPPLEMENTS:

☐ Alcohol Prep Pads **QTY:** _____
☐ Autoject 2 EI **QTY:** _____
☐ FirmTech Tech Ring **QTY:** _____
☐ Constriction Loop **QTY:** _____
☐ FirmTech Performance Ring **QTY:** _____
☐ FirmTech Tech Ring **QTY:** _____

☐ Insul-Tote **QTY:**_____
☐ Insul-Ease **QTY:** _____
☐ Sharps Container **QTY:** _____
☐ N-Acetyl Cysteine 600mg **QTY:** _____
☐ Trimix Starter **QTY:** _____
☐ ICI Essentials **QTY:** _____

VACUUM ERECTION DEVICES & ACCESSORIES

☐ Manual Augusta SomaTherapy System **QTY:**_____
☐ Battery Augusta SomaTherapy System **QTY:** _____

☐ Owen Mumford Manual Vacuum Erection Device **QTY:** _____

Provider Name (Printed):	Provider Signature:

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ERECTILE DYSFUNCTION

◻ MyHixel Control Device + Play App **QTY:** _____ ◻ MyHixel Hands-Free Accessory **QTY:** _____ ◻ MyHixel Replacement Sleeve **QTY:** _____	◻ Promescent Endurance Spray - 60 **QTY:** _____ ◻ Promescent Endurance Spray - 20 **QTY:** _____

◻ Oxytocin 200iu Rapid Dissolve Tablets - Dissolve _____ tablets in mouth _____ times per day _____ **QTY:** _____ **Refills:** _____

PRIAPISM RESCUE

◻ Phenylephrine 1mg/mL **QTY:** 10mL
SIG: Inject _____ units intracavernosal for erections lasting longer than 2.5 hours. Max Dose is 50 units. May repeat in 15 minutes if erection does not subside. May perform a total of 3 doses. Proceed to the emergency room if erection persists.
Refills: _____
◻ Pseudoephedrine 30mg tablet **QTY:** 30 Tablets **Refills:** _____ **SIG:** _____

INTRAURETHRAL GEL:

	Mixture	Phentolamine (mg/mL)	PGE1 (ug/mL)
◻	**GEL**	4	1000
◻	**GEL**	10	-
◻	**GEL**	20	-

QTY: 15mL **Refills:** _____
SIG: Insert _____ mL intraurethrally. Increase or decrease by _____ mL until desired effect is achieved. Maximum dose _____ mL. May use 1x Daily.

PDE5 INHIBITORS

◻ Sildenafil 20mg Tablet **SIG:** Take 20-100mg by mouth as needed, not more than once daily. **QTY:** 90 tab **Refills:** _____
◻ Sildenafil 100mg Tablet **SIG:** Take 100mg by mouth as needed, not more than once daily. **QTY:** 90 tab **Refills:** _____
◻ Vardenafil 12mg Lozenge **SIG:** Dissolve 1 by mouth as needed, not more than once daily. **QTY:** 10 Lozenge **Refills:** _____
Tadalafil Lozenge ◻ 5mg/ ◻ 20mg **SIG:** Dissolve 1 by mouth as needed, not more than once daily. **QTY:** 30 Lozenge **Refills:** _____
Tadalafil Tablet ◻ 5mg/ ◻ 10mg/ ◻ 20mg **SIG:** Take 1 by mouth as needed, not more than once daily. **QTY:** 30 tab **Refills:** _____
Custom SIG: _____

HAIR, HEALTH, AND WELLNESS

◻ Finasteride Tablets - 1mg **SIG:** Take 1 by mouth daily. **QTY:** 30 Tablets **Refills:** _____
◻ Finasteride + Minoxidil Topical Foam 0.1%/ 6% 90mL **SIG:** Apply daily as directed. **Refills:** _____
Valacyclovir ◻ 500mg / ◻ 1,000mg Tablet Take _____ tablet(s) _____ every _____ **QTY:** 30 Tablets **Refills:** _____
SIG: _____

PEYRONIE'S DISEASE

VERAPAMIL	PENTOXIFYLLINE
◻ Verapamil Cream 12% Dispensed in a 30mL Pump Jar **SIG:** Apply 0.5mL (1 Pump) 2x per day for 30 days. **QTY:** (# of 30mL Jars) _____ **Refills:** _____	◻ Pentoxifylline 400mg tablet **SIG:** Take 2 to 3 tablets per day as direct **QTY:** (# of Tablets) _____ **Refills:** _____ ◻ Peyronie's Self-Assessment Tool - Device **QTY:** _____ ◻ Understanding Peyronie's Disease - Book by Dr. Laurence Levine **QTY:** _____

Provider Name (Printed):	Provider Signature:

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HORMONE REPLACEMENT

ANASTROZOLE

☐ Anastrozole Tablets ☐ 1mg **SIG:** Take 1 by mouth per week. **QTY:** 30 Tablets **Refills:** _____

CLOMID: CLOMIPHENE CITRATE

☐ Clomiphene Citrate 25mg Capsules - Take _____ capsules daily _____
QTY: _____ or circle one 15 capsules 30 capsules 45 capsules 60 capsules 90 Capsules **Refills:** _____
☐ Clomiphene Citrate 50mg Capsules - Take _____ capsules daily _____
QTY: _____ or circle one 15 capsules 30 capsules 45 capsules 60 capsules 90 Capsules **Refills:** _____

ENCLOMIPHENE

☐ Enclomiphene 12.5mg Capsules - Take _____ capsules daily _____
QTY: _____ or circle one 15 capsules 30 capsules 45 capsules 60 capsules 90 Capsules **Refills:** _____
☐ Enclomiphene 25mg Capsules - Take _____ capsules daily _____
QTY: _____ or circle one 15 capsules 30 capsules 45 capsules 60 capsules 90 Capsules **Refills:** _____

TESTOSTERONE SUPPLEMENT

☐ Drive Testosterone Support 1 Bottle (30 Capsules)

TESTOSTERONE GEL

☐ 50mg/mL (5) Apply _____ mLs every _____ **QTY** (Total mLs): (numerical and written) _____ mLs **Refills:** _____
☐ 200mg/mL (20%) Apply _____ mLs **Refills:** _____ **QTY** (Total mLs): (numerical and written) _____ mLs **Refills:** _____

TESTOSTERONE PELLETS

☐ Testosterone Pellets 87.5mg **QTY**: (numerical and written) _____ **SIG:** _____
☐ Trocar Kit: 3.5mm Stainless Disposable **QTY**: (numerical and written) _____ **SIG:** _____
☐ Testosterone Pellets 100mg **QTY**: (numerical and written) _____ **SIG:** _____
☐ Trocar Kit: 3.5mm Stainless Disposable **QTY**: (numerical and written) _____ **SIG:** _____
☐ Testosterone Pellets 200mg **QTY**: (numerical and written) _____ **SIG:** _____
☐ Trocar Kit: 4.5mm Stainless Disposable **QTY**: (numerical and written) _____ **SIG:** _____

DEPO TESTOSTERONE CYPIONATE 200mg/mL

☐ Inject _____ mLs _____ ☐ Needles: 18G draw + 23G x 1" for IM injection. QTY: 30
QTY (1) 10mL (TEN) vial **Refills:** _____

GENERIC PREGNYL (HCG)

☐ 1,000iu/mL **QTY** (1) 10mL (TEN) vial **Refills:** _____ **SIG:** Inject _____ mLs _____

CHOOSE SYRINGE: ☐ 1cc: 31 gauge x 5/16" insulin syringes **QTY:** 10 ☐ 1cc: 29 gauge x 1/2" insulin syringes **QTY:** 10

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HORMONE REPLACEMENT

KYZATREX (TESTOSTERONE UNDECANOATE)

☐ Kyzatrex (Testosterone Undecanoate) 200mg Capsules
QTY:____ 120 Capsules **Refills:** _____ **SIG:** Take 2 Capsule/ Twice a Day

ESTRADIOL PELLETS

☐ Estradiol Pellets 10mg **QTY**: (numerical and written) _____ **SIG:** _____
☐ Trocar Kit: 3.5mm Stainless Disposable **QTY**: (numerical and written) _____ **SIG:** _____

DHEA (DEHYDROEPIANDROSTERONE)

☐ DHEA (Dehydroepiandrosterone) 100mg Capsules **QTY:**____ Capsules **Refills:** _____ **SIG:** Take 1 capsule daily

PROGESTERONE

☐ Progesterone 100mg Capsules **QTY:**____ Capsules **Refills:** _____ **SIG:** Take 1 capsule by mouth at bedtime

REQUIRED FOR TESTOSTERONE PRESCRIPTIONS
Patient address: _____
Provider address: _____
Provider DEA Number: _____

Pelvic Health

Overactive Bladder

☐ Mirabegron 20mg Capsules **QTY:** 30 Capsules **Refills:** _____ **SIG:** Take 1 Capsule/ Day
☐ Mirabegron 40mg Capsules **QTY:** 30 Capsules **Refills:** _____ **SIG:** Take 1 Capsule/ Day

☐ ProtechDry Underwear **QTY:** _____
☐ Lunderg Confidence Clamp **QTY:** _____
☐ Minze Diary Pod + App **QTY:** _____

BPH

☐ Finasteride 5mg Tablets: Take 1 Tablet/ Day **QTY:** 90 Tablets **Refills:** _____
☐ Finasteride + Tadalafil 5mg/10mg Capsules: Take 1 Capsule/ Day **QTY:** 90 Capsules **Refills:** _____
☐ Tamsulosin 0.4mg Capsules: Take 1 Capsule/ Day **QTY:** 90 Capsules **Refills:** _____
☐ Tamsulosin + Tadalafil 0.4mg/ 5mg Capsules: Take 1 Capsule/ Day **QTY:** 90 Capsules **Refills:** _____
☐ Flosom + CBD Dietary Supplement 1 bottle (30 capsules)

Bladder Irrigation

☐ Mitomycin Solution 40mg Solution (5mg/mL) Dispense 8mL Vial
SIG: Dilute 8 mLs mitomycin solution with sterile water to produce final concentration
QTY: (# of 8mL Vials) _____ **Refills:** _____

☐ DMSO/ Lidocaine 50%/ .5% (W/V) in 50mL
SIG: Instill into bladder as directed
QTY: (# of 50mL Vials) _____ **Refills:** _____

☐ Mitomycin Sterile Water Kit: **SIG:** Use as directed for dilution of Mitomycin
Kit includes: Chemo-Rated Gloves, Syringe, 18G Needle, Bag and 50mL Sterile Water for injection
***QTY of Kits will match the number of vials of Mitomycin ordered**

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TOPICAL ANESTHETIC

BLT CREAM – Pump Dispenser

☐ Regular Strength (10% Benzocaine/ 5% Lidocaine/ 2 Tetracaine)
☐ Extra Strength (20% Benzocaine/ 6% Lidocaine/ 4% Tetracaine)
QTY: ☐ 30g ☐ 90g **Refills:** _____ **SIG:** ☐ Use as directed ☐ **Custom Sig:** _____

BLT OINTMENT – Ointment Jar

☐ Regular Strength (10% Benzocaine/ 5% Lidocaine/ 2 Tetracaine)
☐ Extra Strength (20% Benzocaine/ 6% Lidocaine/ 4% Tetracaine)
QTY: ☐ 60g ☐ 120g **Refills:** _____ **SIG:** ☐ Use as directed ☐ **Custom Sig:** _____

WOMEN's HEALTH

Vaginal Cream – Estradiol – 0.125mg/mL (0.0125%)

☐ Insert _____ clicks (1 click = 0.25mL = 0.25g) every _____
QTY: (total mLs) _____ or circle one: 15mL 30mL 45mL 60mL 90mL **Refills:**_____

Vaginal Cream – Estradiol/DHEA – 125mg/10mg/mL (0.0125% / 1%)

☐ Insert _____ clicks (1 click = 0.25mL = 0.25g) every _____
QTY: (total mLs) _____ or circle one: 15mL 30mL 45mL 60mL 90mL **Refills:**_____

Vaginal Cream – Testosterone/DHEA/Estradiol – 1mg/3mg/0.5mg/mL

☐ Apply 1 Click Daily **QTY**: (1) 30mL Jar **Refills:** _____

Topical Cream – Estradiol – 1.5mg/mL (0.15%)

☐ Apply _____ pump (1 pump 0.5mL = 05g) every _____
QTY: (total mLs) _____ or circle one: 30mL 60mL 90mL **Refills:** _____

Scream Cream (Libido Cream) – Sildenafil/ Theophylline/ Arginine (2%/ 2.5% 6%)

☐ Apply 1 pump (0.5mL) to the vaginal area 15-30 minutes prior to sexual activity.
QTY: (circle one) 1 Jar (20mL) 2 Jars (40mL) **Refills:** _____

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WELLNESS/LONGEVITY

Low Dose Naltrexone

☐ Low Dose Naltrexone 1.5mg Capsules – Take _____ capsules daily _____

☐ Low Dose Naltrexone 4.5mg Capsules – Take _____ capsules daily _____

Circle one: 15 Capsules 30 Capsules 60 Capsules 90 Capsules **Refills:** _____

Bremelanotide

☐ Bremelanotide 1mg Lozenges – Dissolve _____ lozenge(s) in mouth _____ times per day _____

☐ Bremelanotide 2mg Lozenges – Dissolve _____ lozenge(s) in mouth _____ times per day _____

QTY: _____ **Refills:** _____

Sermorelin Injection 1.5mg/mL

☐ Inject _____ mLs every _____

QTY: 10mL Vials _____

Refills: _____

CHOOSE SYRINGE:

☐ 1cc: 31 gauge x 5/16" insulin syringes **QTY:** 10

☐ 1cc: 29 gauge x 1/2" insulin syringes **QTY:** 10

Ondansetron ODT

☐ Ondansetron ODT 4mg Tablets – Dissolve _____ tablets in mouth _____ times per day _____

QTY: _____ **Refills:** _____

MIC Injection – Methionine/ Inositol/ Choline – (25mg/ 50mg/ 50mg)/mL

☐ MIC Injection 30mL Vial **SIG:** Inject _____ units subcutaneously/ Intramuscularly _____ times per week.

QTY: _____ **Refills:** _____

WELLNESS/ LONGEVITY SUPPLEMENTS

☐ Healthy Weight Essentials – 1 Bottle (60 Capsules) **QTY:** _____ **Refills:** _____

☐ Healthy Weight Essentials – 1 Bottle (120 Capsules) **QTY:** _____ **Refills:** _____

☐ Metabolic Essentials – 1 Bottle (60 Capsules) **QTY:** _____ **Refills:** _____

☐ Metabolic Essentials – 1 Bottle (120 Capsules) **QTY:** _____ **Refills:** _____

☐ Cardio Health Essentials – 1 Bottle (90 Capsules) **QTY:** _____ **Refills:** _____

☐ Collagen Essentials – 8oz Bottle (30 Servings) **QTY:** _____ **Refills:** _____

☐ Probiotic Essentials – 1 Bottle (30 Capsules) **QTY:** _____ **Refills:** _____

Provider Name (Printed):	Provider Signature: