Q1 2025

PharmaLabs

ORDER FORM

California

HOURS:
MON - FRI: 8AM - 9 PM EST
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Call in: (857) 233-5837 x2
Fax in: (888) 247-0840
Write on your preferred EMR via
Pharmalabs - 10901 Roosevelt Blvd N, St. Petersburg, FL 33716

ORDER ON THE PORTAL

The most regulatory compliant way to prescribe medications through PharmaLabs.

PharmaLabs Prescription Order Form – All States FAX: (888) 247-0840

PharmaLabs

☐ **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	–

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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EJACULATORY 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

☐ Pseudoephedrine 30mg tablet **QTY:** 30 Tablets **Refills:** _____ **SIG:** _____

☐ Phenylephrine Kit – (Alcohol Swabs, Gloves, 10mg/1mL Vial (undiluted) and 20mL Vial of Bacteriostatic Water)
QTY: _____ **Refills:** _____

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

☐ 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

☐ 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

TESTOSTERONE GEL

Testosterone Gel 50mg/mL | 20mg/mL

Please prescribe directly to PharmaLabs (10901 Roosevelt Blvd St Petersburg Fl 33716). menMD cannot take pre-printed prescriptions for Controlled Substances via fax in CA.

DEPO TESTOSTERONE CYPIONATE

DEPO Testosterone Cypionate 200mg/mL (1) 10mL Vial.

Please prescribe directly to PharmaLabs (10901 Roosevelt Blvd St Petersburg Fl 33716). menMD cannot take pre-printed prescriptions for Controlled Substances via fax in CA.

KYZATREX (TESTOSTERONE UNDECANOATE)

Kyzatrex (Testosterone Undecanoate) 200mg Capsules

Please prescribe directly to PharmaLabs (10901 Roosevelt Blvd St Petersburg Fl 33716). menMD cannot take pre-printed prescriptions for Controlled Substances via fax in CA.

ESTRADIOL PELLETS

☐ Estradiol Pellets 10mg **QTY**: (numerical and written) _____ **SIG:** _____

☐ Trocar Kit: 3.5mm Stainless Disposable **QTY**: (numerical and written) _____ – _____ **SIG:** _____

TESTOSTERONE SUPPLEMENT

☐ Drive Testosterone Support 1 Bottle (30 Capsules) **QTY:** _____

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:** _____

Provider Name (Printed):	Provider Signature:

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HORMONE REPLACEMENT
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
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:** _____

Provider Name (Printed):	Provider Signature:

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Patient Phone: _____ Email: _____

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)

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

Vaginal Cream - Testosterone/DHEA/Estradiol - 1mg/3mg/0.5mg/mL
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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 _____ **QTY** (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:** _____
Ondansetron ODT
☐ Ondansetron ODT 4mg Tablets – Dissolve _____ tablets in mouth _____ times per day _____ **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: