TWO RIVERS PHARMACY

Men's Health

Prescription Order Form

Please fax to: **910-748-0245** or call in to: **910-748-0243**

101 Broadfoot Ave, Fayetteville, NC 28305

503A compounding pharmacy
USP <797> and <800> compliant
Licensed in North Carolina

Patient Information

PLEASE FAX: Patient demographic sheet & prescription insurance card if available.

FIRST NAME | LAST NAME | DATE OF BIRTH | PHONE #

ADDRESS | CITY, STATE, ZIP | ALLERGIES

Rx Medication Order

Prescriber: you may change the directions, or delete, substitute or add medications.

Pharmacist, please compound:

All creams are dispensed in Topi-Click dispensers.

Testosterone (CIII)	☐ _____ ☐ **cream** ☐ **gel** **%:** ☐ 5 ☐ 10 ☐ 15 ☐ 20 Other: ____ % *Schedule III: the prescriber must hand-write the drug name (testosterone) in the blank above.*	**SIG** ☐ Apply _____ mL to skin, once daily. Dispense: ☐ 30 ☐ 90 days **Refills:**
Testosterone (CIII)	☐ _____ **cypionate 200 mg/mL injection:** ☐ 1 mL vial ☐ 10 mL vial *Schedule III: the prescriber must hand-write the drug name (testosterone) in the blank above.*	**SIG** ☐ Inject _____ mL IM every _____ Dispense: ____ vial(s) **Refills:**
Anastrozole	☐ **Anastrozole capsules, mg:** ☐ 0.25 ☐ 0.5 ☐ 1 ____ mg	**SIG** ☐ Take 1 capsule by mouth twice weekly. ☐ Take 1 capsule by mouth _____ Dispense: ☐ 30 ☐ 90 days **Refills:**
Enclomiphene	☐ **Enclomiphene citrate capsules, mg:** ☐ 6.25 ☐ 12.5 ☐ 25 ☐ 50 Other: ____ mg	**SIG** ☐ Take 1 capsule by mouth, once daily. ☐ Take 1 capsule by mouth _____ Dispense: ☐ 30 ☐ 90 days **Refills:**
Sildenafil	☐ **Sildenafil tablets, mg:** ☐ 25 ☐ 50 ☐ 100	**SIG** ☐ Take 1 tablet by mouth 30 to 60 minutes before sexual activity. No more than once daily. Dispense: ____ tablets **Refills:**
Tadalafil	☐ **Tadalafil tablets, mg:** ☐ 2.5 ☐ 5 ☐ 10 ☐ 20	**SIG** ☐ Take 1 tablet by mouth, once daily. ☐ Take 1 tablet by mouth before sexual activity. No more than once daily. Dispense: ☐ 30 ☐ 90 days **Refills:**

(Optional) Additional instructions or compounds

Prescriber Information

PRESCRIBER NAME AND CREDENTIALS | NPI # | DEA #

STREET ADDRESS | CITY, STATE, ZIP | PHONE | FAX

PRESCRIBER'S SIGNATURE | **DATE**

Want these forms preprinted with your practice's information? Email travin@tworiversrx.com or call 910-748-0243.

This form is a prescription when signed by a licensed prescriber. A pharmacist will verify the order and contact your office with any questions before compounding.