

Supervising Physician's Name(MD/DO Only)	DEA#	Phone	Fax
Practice Name & Address		City	State Zip
Patient Name		DOB	Phone

Bill To: Office Patient |
 Ship To: Office Patient

<input type="checkbox"/> Prostaglandin _____ mcg/mL Injectable	<input type="checkbox"/> BiMix Pap 30 mg/mL Phent 1 mg/mL Injectable	<input type="checkbox"/> TriMix 1 Pap 15 mg/mL Phent 0.5 mg/mL PGE ₁ 5 mcg/mL Injectable	<input type="checkbox"/> TriMix 2 Pap 30 mg/mL Phent 1 mg/mL PGE ₁ 10 mcg/mL Injectable	<input type="checkbox"/> TriMix 3 Pap 30 mg/mL Phent 2 mg/mL PGE ₁ 20 mcg/mL Injectable	<input type="checkbox"/> TriMix 4 Pap 40 mg/mL Phent 3 mg/mL PGE ₁ 40 mcg/mL Injectable	<input type="checkbox"/> QuadMix Pap 30 mg/mL Phent 2 mg/mL PGE ₁ 20 mcg/mL Atropine 0.15 mcg/mL Injectable
Custom Formula						
Papaverine_____mg Phentolamine_____mg Prostaglandin_____mcg Atropine_____mcg Sig: Inject _____ mL as directed.						
Quantity: <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL				Refills: _____ 1 2 3 NR		

<input type="checkbox"/> Tadalafil 10mg "Mini" Troche <input type="checkbox"/> Tadalafil 20mg "Mini" Troche <input type="checkbox"/> Tadalafil 40mg Troche Sig: Take 1 Troche in pouch of cheek prior to activity. Do not swallow QTY: _____ Capsules / Troches Refills: _____ 1 2 3 NR	<input type="checkbox"/> Sildenafil 110 mg Caps <input type="checkbox"/> Sildenafil 110 mg Fluoxetine 5 mg Caps <input type="checkbox"/> Sildenafil 55 mg Caps <input type="checkbox"/> Sildenafil 55 mg Fluoxetine 5 mg Caps Sig: Take 1 Capsule By Mouth prior to sexual activity as directed.
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Testosterone Pellet	Qty
50mg	
100mg	
200mg*	

*Requires 4.5mm Trocar
Sig: Insert pellets for in office procedure

Supplies

3.2mm Trocar Kit
 4.5mm Trocar Kit

Testosterone Topical Gel 5% (50mg/mL) Sig: Apply _____ mL QD x 30 Days <input type="checkbox"/> 30 mL <input type="checkbox"/> 60 mL <input type="checkbox"/> 90 mL Refills: _____ 1 2 3 NR	Testosterone Cypionate / Testosterone Propionate in Sesame Oil 160 mg/mL / 40mg/mL Sig: Inject _____ mL IM Q Weekly Qty: 10mL (2 x5mL vials) Refills: _____ 1 2 3 NR	Testosterone Cypionate Injectable in Sesame Oil <input type="checkbox"/> 50 mg/mL <input type="checkbox"/> 100 mg/mL <input type="checkbox"/> 200 mg/mL Sig: Inject _____ mL IM Q Weekly Qty: 10mL (2 x5mL vials) Refills: _____ 1 2 3 NR	hCG Injectable <input type="checkbox"/> 1,000 Units/mL <input type="checkbox"/> 5,000 Units/mL Sig: Inject _____ hCG Units SQ Twice Weekly Qty: 10mL (2 x5mL vials) Refills: _____ 1 2 3 NR	Anastrozole 1mg Tablets Sig: Take _____ Tablet PO _____ Weekly Qty: 10 Tablets Refills: _____ 1 2 3 NR	Sermorelin & GHRP <input type="checkbox"/> Sermorelin 6mg/GHRP-2 6mg/GHRP-6 3mg <input type="checkbox"/> Sermorelin 9mg/GHRP-2 3mg <input type="checkbox"/> Sermorelin 9mg Qty: _____ 6mL Vial(s) Sig: Inject _____ mL SQ Each Night Refills: _____ 1 2 3 NR
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Prescriber's Signature (MD, DO, NP, or PA Only): _____ DEA#: _____ Date: _____

All of the above products are compounded preparations with the exception of anastrozole. Innovation Compounding makes no claims of safety and/or efficacy as these compounded products have not been evaluated or approved by the FDA.