

LDN (Low-Dose Naltrexone) Titration/Maintenance



121 Harmony Xing Ste 3
Eatonton, GA 31024
Ph: (762) 777-7001 – Fax: (762) 777-7002
mypharmacist@lakecountrypharmacy.com
www.lakecountrypharmacy.com

Please Send Patient Demographics
Along With New Prescription
Orders, Including List of Patient
Allergies & Insurance
Information/Social Security #

Patient Name: _____ Date of Birth: _____
Address: _____ Patient Phone: _____

Person Faxing Request: _____
Prescriber Name: _____ Prescriber Phone: _____
Prescriber DEA: _____ NPI: _____ Prescriber Fax: _____

* ANY INGREDIENTS OR STRENGTHS ON THE FORM MAY BE CHANGED OR DELETED AT PRESCRIBERS DISCRETION *

* THIS LIST IS NOT ALL-INCLUSIVE, PLEASE CALL WITH ANY QUESTIONS OR REQUESTS *

* PLEASE CHECK THE DESIRED PRESCRIPTION ORDER, MARK THE NUMBER OF REFILLS, SIGN & DATE BELOW *

Low-Dose Naltrexone Titration Starter Titration (Take liquid dose as prescribed 30-60 minutes before bedtime, store at room temperature)

Naltrexone 5mg/ml: 35mL

Sig: Take as directed on titration schedule 30-60 minutes every day before bedtime; when relief is achieved contact pharmacy or prescriber to discuss your dose and the relief achieved

Week
Week 1 (days 1-7): 0.3mL per day (1.5mg)
Week 2 (days 8-14): 0.4mL per day (2mg)
Week 3 (days 15-21): 0.5mL per day (2.5mg)
Week 4 (days 22-28): 0.6mL per day (3mg)
Week 5 (days 29-35): 0.7mL per day (3.5mg)
Week 6 (days 36-42): 0.8mL per day (4mg)
Week 7 (days 43-49): 0.9mL per day (4.5mg)

*** Once desired dose is achieved, or patient symptoms are sufficiently resolved, next Rx can be written as follows:

LDN Oral Suspension Maintenance Dosing

Naltrexone Oral Suspension (5mg/mL) -- ** May change to Gel Tab Dosage form on Maintenance Doses by circling * GEL TAB * here **

(Please circle desired daily dose) 1.5mg 2mg 2.5mg 3mg 3.5mg 4mg 4.5mg Other _____

Take prescribed dose (noted above) by mouth every day, 30-60 minutes before bedtime

Please circle/write desired quantity 1 month 2 months 3 months Refills _____

Naltrexone 1mg/mL Oral Suspension (for Micro-dosing -- please indicate desired mg/dose below)

Take _____ ml (= _____ mg) by mouth every evening as directed

Please circle/write desired quantity 1 month 2 months 3 months Refills _____

**** Patients with Hashimoto's and Graves' disease: Patients should be monitored for symptoms of fast pulse, palpitations, or sudden onset of insomnia. If any of these occur, thyroid adjustment may be needed. ****

Prescriber Signature: _____ Date: _____