

Topical Pain Management



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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: _____

(Please Check Desired Formula, May Make Adjustments as Desired – then circle desired quantity and refills at bottom of page)

Anti-Inflammatory (To delete medications, cross out, may make additions/substitutions if desired)

____ Diclofenac 6%
____ Ketoprofen 10% -- OR -- 20% (please circle desired strength)
____ Baclofen 2%, Cyclobenzaprine 2%, Diclofenac 3%, Ketoprofen 10%, Lidocaine 5%

Neuropathic (To delete medications, cross out, may make additions/substitutions if desired)

____ Baclofen 2%, Cyclobenzaprine 2%, Gabapentin 6%, Ketamine 5%, Lidocaine 5%

Combination (Musculoskeletal/Inflammation/Fibromyalgia/Myofascial)

(To delete medications, cross out, may make additions/substitutions if desired)

____ Baclofen 2%, Cyclobenzaprine 2%, Diclofenac 6%, Gabapentin 6%, Lidocaine 5%
____ Baclofen 2%, Gabapentin 6%, Ketamine 5%, Ketoprofen 10%, Lidocaine 2%

Shingles/Post-Shingles

(To delete medications, cross out, may make additions/substitutions if desired)

____ Acyclovir 5%, Amitriptyline 4%, Diclofenac 6%, Gabapentin 10%, Lidocaine 5%
____ Amitriptyline 4%, Diclofenac 6%, Gabapentin 10%, Lidocaine 5%

Dispense (circle one): 50gm 100gm 150gm 200gm **Refills (circle one):** 0 1 2 3 4 5 PRN

Sig: Apply 1-2 grams to affected area 3-4 times per day as directed

- *Base Cream includes 3% Pentoxifylline for improved circulation and absorption at application site*

Prescriber Signature: _____ **Date:** _____