

Ketamine Preparations



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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: _____

**** This list is not all inclusive ****

**** Directions may be modified below as needed ****

**** If different doses, medications, or delivery methods are required,
please contact the pharmacy with any questions or requests ****

- **Ketamine 100mg/ml SL Suspension**

Directions: Take _____ mL under the tongue (hold for 60 seconds before swallowing) daily at bedtime as directed

Quantity: _____ **Refills:** _____

- **Ketamine 100mg/ml (10mg/spray) Nasal Spray (0.1mL per actuation)**

**** Please write in desired # of sprays below based on required dosage ****

Directions: Use _____ sprays in one nostril daily at bedtime, or as directed by physician

Directions: Use _____ sprays in one nostril at bedtime 2 to 3 days per week, or as directed by physician

(Please circle desired quantity)

Quantity: (please circle) **15mL - 30mL - 45mL - 60mL** **Refills:** _____

- **Ketamine 10% Transdermal Cream**

Directions: Apply 1-2 grams topically to the affected area(s) 3-4 times per day as directed

Quantity: (please circle) **50gm 100gm** **Refills:** _____

Prescriber Signature: _____ **Date:** _____