Express RX Pharmacy

1711 W. Temple St. #100 Los Angeles, CA 90026
Phone-213-353-0552 Fax-213-674-2259

Prescription Request Form

Patient Name: _____ DOB: _____
Address: _____
Diagnosis: _____ ICD-9 Codes: _____

MISCELLANEOUS SUPPLIES **Sig: use with INSULIN pump site changes every 2-3 days.**

☐ Skin Barrier Wipes, #50 / month	☐ Adhesive Removal Wipes #50 / month
☐ Transparent Film Dressing 6cmx7cm #12 / mo	☐ _____

CHANGE OF INSULIN SYRINGE

	CHOOSE:	*CHOOSE:*
☐ 1 cc		
☐ 3/10 cc	**6 mm**	**31 gauge**
☐ 0.5 cc	8 mm	30 gauge

☐ 3/10cc WITH ½ unit marking

Sig: Use _____ daily for insulin administration.

CHOOSE : BD PEN NEEDLES SIZE 31g

☐ (nano = 4mm)
☐ (mini = 5mm)
☐ (short = 8mm)

Sig: Use _____ daily for insulin administration.

GLUCAGON KIT **Dispense quantity _____, use 1 for HOME + 1 for SCHOOL.**

Inject _____MG__ into muscle as needed for severe hypoglycemia, seizure or loss of consciousness.

TESTING SUPPLIES

☐ _____ Test strips, Testing _____ times daily. QTY_____
☐ _____ lancets, Testing _____ times daily. QTY_____
☐ _____ KETONE strips, Test when BS over 300 twice, or when ill. QTY 10 / dispense.
☐ Ketostix (50/box) Use to test urine, if BS > 250 twice, or when ill. QTY 100 / dispense.

Insulin

☐ HUMALOG or NOVOLOG vial / pens
Use up to _____ units daily. QTY _____ / month.

☐ LANTUS or LEVEMIR vial / pens
Use up to _____ units daily. QTY _____ / month

☐ Apidra

☐ Humulin N

Refills on supplies: _____ / **PRN** **30DAY SUPPLY**

Physician Signature: _____ **Date**: _____

Physician Name: _____ NPI:_____ Lic:_____

Address: _____ City/State: _____Zip: _____ Ph:_____
Fax:_____

Complete and Fax back to: 213-674-2259