Patient Name: _____Date of Birth: _____Date:_____

Address: _____

Cell Phone: _____ Home Phone: _____

Allergies: _____

Compounded Medications

INTERCAVERNOUS SELF-INJECTION ORDER (Choose One or Write in Custom Mixture)	**ORDER INSTRUCTIONS:**
☐ **PGE – 30mcg Prostaglandin per ml**	• Inject _____units • Intracavernosally as instructed. • Increase or decrease by _____units, until desired effect achieved. • Maximum dose ____units. **DISPENSE:** 5ML Vial Qty: _____ **SYRINGES:** INCLUDES #20 Insulin 30G x ½" Or Choose: ☐ Insulin Shorts 31G x 5/16" ☐ _____ **REFILL:** _____
☐ **PGE – 40 mcg Prostaglandin per ml**	
☐ **BIMIX 1- 30mg Papaverine, 0.5mg Phentolamine per ml**	
☐ **BIMIX 2 – 30mg Papaverine, 1mg Phentolamine per ml**	
☐ **BIMIX 4 – 30mg Papaverine, 2mg Phentolamine per ml**	
☐ **TRIMIX 1 – RED – 30mg Papaverine/0.5mg Phentolamine/10mcg Prostaglandin/ml**	
☐ **TRIMIX 2 - SILVER – 30mg Papaverine/1.0mg Phentolamine/10mcg Prostaglandin/ml**	
☐ **TRIMIX 3 – GOLD – 30mg Papaverine/2.0mg Phentolamine/20mcg Prostaglandin/ml**	
☐ **TRIMIX 4 – DIAMOND 30mg Papaverine/1.0mg Phentolamine/40mcg Prostaglandin/ml**	
☐ **TRIMIX 5 – PLATINUM 30mg Papaverine/2.0mg Phentolamine/40mcg Prostaglandin/ml**	
Custom Mixture: **Papaverine _____mg/mL Phentolamine _____mg/mL** **Prostaglandin _____mcg/mL Atropine _____mg/mL**	

Accessories: ☐ **ID-300 Auto-Injector** ☐ **Home Sharps Container** ☐ **Travel Tote (Insulin Syringe -Type)**

☐ **Priapism Antidote Kit** (Beyond Use Date: 365 days) Phenylephrine 10mg/mL SDV, Sodium Chloride 0.9% SDV, #10 -1mL tuberculin 27Gx 1/2" syringes & alcohol pads	**SIG:** Use As Directed. Select here ☐ if pharmacy to Include patient instructions for use of Priapism Antidote Kit. **Refill:** _____
☐ **Verapamil Lipoderm Gel 15% (150mg/mL)** #30 Mega Pump (1 pump = 1/2mL	**SIG:** Apply 1 pump to shaft twice daily and rub in well. **Refill:** _____
☐ **Oxytocin Nasal 100units/ml Solution** Dispense: ___2ml ___5ml	**SIG:** Apply 1 nasal spray in each nostril ½ hour before activity. **Refill:**_____
☐ **Oxytocin/Tadalafil Capsule** Strength: __100U/5mg __125U/25mg	**SIG:** Take 1 capsule PO 30-60 minutes before sexual intercourse. **Qty to Dispense**: #_____ **Refill:** _____
☐ **Sildenafil Sublingual Troches** Strength: __50mg __100mg Other: _____mg Flavor: __Mint __Butter Rum	**SIG:** Dissolve one troche between cheek and gum. Allow to dissolve and absorb 30 minutes before sexual intercourse. **Qty to Dispense**: #_____ **Refill:** _____
☐ **Sildenafil __20mg __50mg __100mg Tablets**	**SIG:**_____ **Qty to Dispense**: #_____ **Refill:**_____
☐ **Tadalafil Sublingual Troches** Strength: __5mg __10mg __20mg Flavor: __Mint __Butter Rum	**SIG:** Dissolve 1 troche between cheek & gum, as directed (__once a day or __30 minutes before sexual activity). **Qty to Dispense: #_____ Refill:** _____
☐ **Lidocaine 1.5 % (Delay Gel) *18gm Pump***	**SIG:** Apply 1-2 pump (0.25-0.50gm) 20-30 min to penis gland prior to intercourse. **Qty to Dispense: #_____ Refill:** _____

Dr. Signature: _____ Dr. Name (Print):_____

Office Address: _____

Office Tel: _____ Staff Contact: _____

Charge: ☐ Patient ☐ Dr's Office Dispense: ☐ Pick-up or Send To: ☐ Patient ☐ Dr's Office