

# Physician's Medication Order Form

www.LibertyDrug.com



**LIBERTY DRUG**

195 Main Street - Chatham, NJ 07928  
(Phone) 877.836.0111 (Fax) 973.635.6208

PHYSICIAN NAME: \_\_\_\_\_ DEA# \_\_\_\_\_ NPI# \_\_\_\_\_

PHYSICIAN ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHYSICIAN PHONE: \_\_\_\_\_ PHYSICIAN FAX: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**WART FILM PLUS** *5-Fluorouracil 5%/ Levamisole 0.2%/ 2-Deoxy-D-Glucose 1%/ Salicylic Acid 20% in DMSO*

DIRECTIONS:

1. Soak foot or other area to be applied for 5 to 10 minutes in warm water.
2. Gently rub skin around wart with a nail/emery board to remove dead skin / old medicine and help soften skin.
3. Use the brush to lightly apply the medication to the wart(s). Use care to avoid applying medication to healthy skin. The medication will break down healthy skin as well as the warts.
4. Allow medication to dry. Cover the wart with a bandage or piece of paper tape.
5. Put the cap back tightly on the bottle and store upright.
6. Wash hands after applying. NEVER put WART FILM PLUS in mouth, nose or eyes.
7. In case of accidental ingestion or contact with eyes, nose or mouth, contact the Poison Control Center at (800) 962-1253

**TERBINAZOLE NAIL FILM** *Terbinafine 2.5% / Econazole  1% or  5% in DMSO*

DIRECTIONS:

1. Soak foot or other area to be applied for 5 to 10 minutes in warm water.
2. Use the brush to lightly apply the medication to the nail(s). Use care to avoid applying medication to skin.
3. Allow medication to dry for 3-4 minutes
4. Put the cap back tightly on the bottle and store upright.
5. Wash hands after applying. NEVER put TERBINAZOLE NAIL FILM in mouth, nose or eyes.
6. In case of accidental ingestion or contact with eyes, nose or mouth, contact the Poison Control Center at (800) 962-1253

**PF GEL** (*Plantar Fasciitis*) *Ketoprofen/Ketamine/Amitriptyline/Carbamazepine/Diphenhydramine/Ibuprofen/Cyclobenzaprine*

DIRECTIONS:

Apply 3-4 drops to painful area and massage in well two to four times a day

PATIENT NAME: \_\_\_\_\_ GENDER: \_\_\_\_\_ DOB: \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

The documents accompanying this telecopy transmission contain confidential information belonging to the sender that is legally privileged. It is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. Thank you.

**FAX (973) 635-6208**