

Physician's Medication Order Form:

Rosacea



LIBERTY DRUG

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www.LibertyDrug.com

LibertyDrugRx@gmail.com

PHYSICIAN NAME: _____ DEA# _____ NPI# _____

PHYSICIAN ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHYSICIAN PHONE: _____ PHYSICIAN FAX: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Azelaic Acid 15%, Niacinamide 2% Cream

DIRECTIONS:

Apply a thin film to affected area twice a day

Azelaic Acid 15%, Metronidazole 1%, Ivermectin 1% Cream

DIRECTIONS:

Apply a thin film to affected area twice a day

Other:

DIRECTIONS:

PATIENT NAME: _____ GENDER: _____ DOB: _____

PATIENT ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

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