PRESCRIBER TREATMENT LISTS

World's Best Formulations / Lowest Prices Nationwide

1. Treatment List # 1 (Page 3)
   - Anti-Aging Treatments
2. Treatment List # 2 (Page 5)
   - Male Hormone Replacement
3. Treatment List # 3 (Page 7)
   - Female Hormone Replacement
4. Treatment List # 4 (Page 9)
   - Sexual Dysfunction Treatments
5. Treatment List # 5 (Page 11)
   - Weight-Loss Treatments
   - Thyroid Medicine (Natural)
   - Diabetes Treatments
6. Treatment List # 6 (Page 13)
   - Pain Management Treatments
7. Treatment List # 7 (Page 15)
   - Dermatology Treatments
8. Treatment List # 8 (Page 17)
   - Ear, Nose & Throat Treatments
9. Treatment List # 9 (Page 19)
   - Rheumatology Treatments
   - Autoimmune Disease Treatment
10. Treatment List # 10 (Page 21)
    - Migraine Treatments
    - Sleep/Anxiety Treatments
11. Treatment List # 11 (Page 23)
    - Podiatry Treatments
12. Treatment List # 12 (Page 25)
    - Various Treatments
    - Custom Compounding Worksheet

INSTRUCTIONS FOR ORDERING

(1) Make Copies & Fax to Pharmacy - Remove the staple, make copies of the **front and back side** of any treatment list. Complete all information from both sides and **Fax To: 954-606-5260**

(2) Custom Orders – a prescriber may change any ingredient, strength, dosage form, quantity or directions for use to better meet the needs of an individual patient. (See Worksheet – Page 25)

(3) Please Note - If any medication you select contains a schedule CIII or CIV controlled substance, one of our pharmacists will place a follow-up telephone call to your office to verify the prescription(s) and further document it as a verbal order with a signed faxed copy received prior to dispensing.

MedLab Compounding Pharmacy: Phone 954-400-0560 Fax To 954-606-5260

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DELIVERY INSTRUCTIONS

ALL ORDERS ARE SHIPPED FOR NEXT-DAY DELIVERY

(In remote locations USPS/UPS delivery may take 2 days.)

The Price of a custom preparation must be obtained after the prescription is received so it can be calculated accurately at that time of the order and quoted to the patient before the preparation is compounded and shipped.

AUTO-SHIP PROGRAM BENEFITS

In addition to receiving VIP discounted batch pricing, the purpose of our Auto-Ship Program is to provide a convenient way for patients to stay compliant with their dosage regimens.

All Auto-Ship orders are batched and shipped on a weekly basis according to their cycle fill dates. Patients must designate how often they want to receive their Medicine so they arrive one week before their run out date.

When prescriptions placed on Auto-Ship run out of refills, prescribers and patients are notified ahead of time, so patients can stay compliant with their dosage regimens before their medications run out.

PACKAGING AND SHIPPING COSTS

1. Cost for **Room-Temperature** Tamper-Resistant Packaging with Shipping: **$12**

2. Cost for **Cooler Plus Frozen Ice-Packs** in Tamper-Resistant Packaging with Shipping: **$15**

PHONE: 954-400-0560

TREATMENT LIST #1

FAX TO: 954-606-5260

MedLab Compounding Pharmacy

SECTION A – PATIENT INFORMATION: **SHIP TO PATIENT**

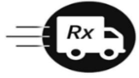
Patient Name: Male___ Female___	D.O.B:	Phone:	
Ship To Address:	City:	State:	Zip:
Drug Allergies:			

ANTI-AGING – BRAIN AGING, ACTIVITY LEVEL, FOCUS, MEMORY, SEXUAL ACTIVITY, FACIAL AGING, HAIR LOSS:

Product	Formula
[ ] **ActiveLife-10™ Sublingual Tabs** (Anti-Aging, Activity , Memory) **(BioMax)**	**Selegiline 0.1mg (Deprenyl) + Ergoloid Mesylates 1mg + CoQ10 30mg Sublingual Tablets (BioMax™)** **Sig**: Dissolve one (1) tablet under the tongue every 12 hours. **CIRCLE QTY**: **60** - or - **180**
[ ] **SubMORELIN 2+6™ SL Tablets** (HGH Releasing Peptides) **(BioMax)**	**Sermorelin + GHRP 2 + GHRP 6 (200/100/100mcg) Sublingual Tablets (BioMax™)** **Sig**: Dissolve one (1) tablet under the tongue once daily before bedtime. **CIRCLE QTY**: **30** - or - **90**
[ ] **SubTREXONE™ (LDN) SL Tabs** (Pain, Autoimmune, Inflammation) **(BioMax)**	**Naltrexone 1.5mg (LDN) Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **30** - or - **90** **Sig**: Dissolve one (1) tablet under the tongue once daily before bedtime.
[ ] **LipoTREXONE™ SL Tabs (BioMax)** (Diabetes , Obesity, Brain Function)	**Alpha-Lipoic Acid 40mg + Naltrexone 1.5mg (LDN) Sublingual Tablets (BioMax™)** **Sig**: Dissolve one (1) tablet under the tongue once daily before bedtime. **CIRCLE QTY**: **30** - or - **90**
[ ] **FacialDerm™ Face Cream (BioMax)** (Inflammation, Moisture, Circulation)	**Pentoxifylline 5% + Hyaluronic Acid .03% (Micronized) Facial Cream (BioMax™)** **Sig**: Rub 1-2 pumps full into affected area every 12 hours. **CIRCLE QTY**: **30gm** - or - **90gm**
[ ] **ProEstraDERM-10™ Face Cream** (Facial-Aging) **(BioMax)**	**Estradiol 0.01% + Estriol 0.3% + Progesterone 2% + CoQ10 0.3% + Tretinoin 0.025% Facial Cream** **Sig:** Massage 1-2 pumps full gently into the facial skin twice daily. **(BioMax™)** **CIRCLE QTY**: **60g** - or - **180g**
[ ] **BioMax-M™ Hair-Loss Formula** (Worlds #1 Formula For Men) **(BioMax)**	**Minoxidil 15% + Finasteride 0.1% + Tretinoin 0.025% (Micronized) Topical Hair-Formula (For Men)** **Sig**: Spray and rub 1-2 pumps full into the affected areas on scalp twice daily. **CIRCLE QTY**: **60ml** - or - **180ml**
[ ] **BioMax-W™ Hair-Loss Formula** (Worlds #1 Formula For Women) **(BioMax)**	**Minoxidil 5% + Azelaic Acid 5% + Tretinoin 0.025% (Micronized) Topical Hair-Formula (For Women)** **Sig**: Spray and rub 1-2 pumps full into the affected areas on scalp twice daily. **CIRCLE QTY**: **60ml** - or -**180ml**
[ ] **Botox-Like™ Facial Lotion** (Wrinkles, Photo Aging) **(BioMax)**	**Adenosine 0.3% + Acetyl Hexapeptide 5% + Tretinoin 0.025% (Micronized) Facial Lotion** **Sig**: Rub 1-2 pumps into the affected areas before bedtime. **(BioMax™)** **CIRCLE QTY**: **30gm** - or – **90gm**

SECTION B – PRESCRIBER PLEASE COMPLETE, SIGN, AND DATE:

Prescribers Name (Print) & Signature:		**Auto-Ship Refills:** PRN (Include Auto-Ship Discount) or Other ___	
Street:	City:	State:	Zip:
NPI:	DEA:	Phone:	Fax:

	**MedLab Pharmacy** **[Fax To: 954-606-5260]**

Telephone: 954-400-0560 **Fax To: 954-606-5260**

COMPOUND DRUG - PAYMENT OPTIONS

Payment Total Includes: Preparation Cost + Tamper-Resistant Shipping Cost

PAYMENT OPTIONS: Mark [X] next to your payment preference, complete form and fax with order.

1. [ ] Charge the first order **plus** all additional refills thereafter to the **patient**.

2. [ ] Charge the first order **only** to the **prescriber's office**. Charge all refills thereafter to the **patient**.

3. [ ] Charge the first order **plus** all additional refills thereafter to the **prescriber's office.**

PATIENT'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

Billing Address ____

City______________________________ State _____ Zip__________________________

Credit Card Number__________________________________ Exp Date:___/______ CVV_____

Checking Account# ________________________ABA (9 digits)______________________

Authorized Signature:____

PRESCRIBER'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

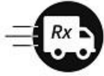
Billing Address ____

City______________________________ State _____ Zip__________________________

Credit Card Number________________________________ Exp Date:_____/______ CVV_____

Checking Account# ________________________ABA (9 digits)______________________

Authorized Signature:____



PHONE: 954-400-0560 | **TREATMENT LIST #2** | **FAX TO: 954-606-5260**

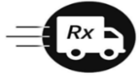
SECTION A – PATIENT INFORMATION:	**MedLab Compounding Pharmacy**		**SHIP TO PATIENT**	
Patient Name: **Male___ Female___**		**D.O.B:**	**Phone:**	
Ship To Address:	**City:**		**State:**	**Zip:**
Drug Allergies:				

MEN'S HEALTH & WELLNESS - (BHRT) BIO-IDENTICAL HORMONE REPLACEMENT THERAPY:

Product	Details
[ ] **SubTest™ (Men) SL Tablets** (Men's TRT) **(BioMax)**	**Testosterone 25mg Sublingual Tablets (BioMax™)** **QTY (30 Days Max): 60** (Sixty) **or Other____** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours. **Auto-Ship Refills: 5 or other____**
[ ] **Anastrozole-SL™ SL Tablets** (Estrogen Formation Blocker) **(BioMax)**	**Anastrozole 0.25mg Sublingual Tablets (BioMax™)** **CIRCLE QTY: 60** – or - **180** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours.
[ ] **SubTest-A™ Sublingual Tablets** (Men's TRT) **(CIII) (BioMax)**	**Testosterone 25mg + Anastrozole 0.25mg Sublingual Tablets (BioMax™) Auto-Ship Refills: 5 or Other___** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours. **QTY (30 Days Max): 60** (Sixty) **or Other___**
[ ] **Trifecta-SL™ Sublingual Tablets** (Men's TRT) **(CIII) (BioMax)**	**Testosterone 25mg + Anastrozole 0.25mg + HCG 250IU SL Tabs (BioMax™) Auto-Ship Refills: 5 or Other ___** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours. **QTY (30 Days Max): 60** (Sixty) **or Other___**
[ ] **SubMORELIN 2+6™ SL Tablets** (HGH Releasing Peptides) **(BioMax)**	**Sermorelin + GHRP 2 + GHRP 6 (200/100/100mcg) Sublingual Tablets (BioMax™)** **Sig**: Dissolve one (1) tablet under the tongue once daily before bedtime. **CIRCLE QTY: 30** - or - **90**
[ ] **SubTropin-12™ (HCG) SL Tablets** (Testicular Atrophy) **(BioMax)**	**HCG 250IU + B12 1000mcg Sublingual Tablets (BioMax™)** **CIRCLE QTY: 60** - or - **180** **Sig**: Dissolve one (1) tablet under the tongue every 12 hours.
[ ] **DHEA-SL™ Sublingual Tablets** (Men's BHRT) **(BioMax)**	**DHEA 25mg Sublingual Tablets (BioMax™)** **CIRCLE QTY: 60** –or- **180** **Sig**: Dissolve one (1) tablet under the tongue every 12 hours.
[ ] **Pregnenolone-SL™ SL Tablets** (Men's HRT) **(BioMax)**	**Pregnenolone 25mg Sublingual Tablets (BioMax™)** **CIRCLE QTY: 60** –or- **180** **Sig**: Dissolve one (1) tablet under the tongue every 12 hours.
[ ] **BetaSterol-SL™ Sublingual Tabs** (Men's HRT) **(BioMax)**	**Beta-Sitosterol 25mg Sublingual Tablets (BioMax™)** **CIRCLE QTY: 60** –or- **180** **Sig**: Dissolve one (1) tablet under the tongue every 12 hours.

SECTION B – PRESCRIBER PLEASE COMPLETE, SIGN, AND DATE:

Prescribers Name (Print) & Signature:		**Auto-Ship Refills:** PRN (Include Auto-Ship Discount) or Other ___	
Street:	**City:**	**State:**	**Zip:**
NPI:	**DEA:**	**Phone:**	**Fax:**

	**MedLab Pharmacy** **[Fax To: 954-606-5260]**

Telephone: 954-400-0560 **Fax To: 954-606-5260**

COMPOUND DRUG - PAYMENT OPTIONS

Payment Total Includes: Preparation Cost + Tamper-Resistant Shipping Cost

PAYMENT OPTIONS: Mark [X] next to your payment preference, complete form and fax with order.

1. [ ] Charge the first order **plus** all additional refills thereafter to the **patient**.

2. [ ] Charge the first order **only** to the **prescriber's office**. Charge all refills thereafter to the **patient**.

3. [ ] Charge the first order **plus** all additional refills thereafter to the **prescriber's office.**

PATIENT'S PAYMENT METHOD: Credit Card -or- Checking Account Information
Name on Credit Card or Checking Account ____
Billing Address ____
City_________________________________ State _____ Zip___________________________
Credit Card Number____________________________________ Exp Date:___/______ CVV_____
Checking Account# ___________________________ABA (9 digits)_______________________
Authorized Signature:____

PRESCRIBER'S PAYMENT METHOD: Credit Card -or- Checking Account Information
Name on Credit Card or Checking Account ____
Billing Address ____
City_________________________________ State _____ Zip___________________________
Credit Card Number__________________________________ Exp Date:_____/______ CVV_____
Checking Account# ___________________________ABA (9 digits)_______________________
Authorized Signature:____

PHONE: 954-400-0560

TREATMENT LIST #3

FAX TO: 954-606-5260

SECTION A – PATIENT INFORMATION:	MedLab Compounding Pharmacy		SHIP TO PATIENT
Patient Name: Male___ Female___	D.O.B:		Phone:
Ship To Address:	City:	State:	Zip:
Drug Allergies:			

WOMEN'S HEALTH & WELLNESS - (BHRT) BIO-IDENTICAL HORMONE REPLACEMENT THERAPY:

Product	Description
[ ] **SubEstra-E2™ Sublingual Tabs** (Female BHRT) **(BioMax)**	**Estradiol (E2) 1mg Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **60** – or- **180** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours.
[ ] **SubEstra-E3™ Sublingual Tabs** (Female BHRT) **(BioMax)**	**Estriol (E3) 2.5mg Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **60** – or- **180** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours.
[ ] **BiEst-SL™ Sublingual Tablets** (Female BHRT) **(BioMax)**	**Estradiol (20%) + Estriol (80%) 2mg Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **60** – or- **180** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours.
[ ] **SubBiEst-P™ Sublingual Tabs** (Female BHRT) **(BioMax)**	**Estradiol (40%) + Estriol (60%) (2mg) + Progesterone 25mg Sublingual Tablets (BioMax™)** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours. **CIRCLE QTY**: **60** – or- **180**
[ ] **TriEst-SL™ Sublingual Tablets** (Female BHRT) **(BioMax)**	**Estradiol (40%) + Estriol (60%) 3mg Sublingual Tablets (BioMax™)** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours. **CIRCLE QTY**: **60** – or- **180**
[ ] **SubTriEst-P™ Sublingual Tabs** (Female BHRT) **(BioMax)**	**Estradiol (40%) + Estriol (60%) 3mg + Progesterone 25mg SL Tabs (BioMax™)** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours. **CIRCLE QTY**: **60** – or- **180**
[ ] **Progesterone-SL™ SL Tablets** (Female BHRT) **(BioMax)**	**Progesterone 25mg Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **60** – or- **180** **Sig**: Dissolve one (1) tablet under the tongue every 12 hours.
[ ] **SubTest™ (Women) SL Tablets** (Female BHRT) **(CIII) (BioMax)**	**Testosterone 2.5mg Sublingual Tablets (BioMax™)** **QTY (30 Days Max)**: **60** (Sixty) **or other____** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours. **Auto-Ship Refills: 5 or other____**
[ ] **Estra-T™ (Women) SL Tablets** (Female BHRT) **(CIII) (BioMax)**	**Estradiol 1mg + Testosterone 2.5mg Sublingual Tabs (BioMax™)** **QTY (30 Days Max)**: **60** (Sixty) **or other___** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours. **Auto-Ship Refills: 5 or other____**
[ ] **Estradiol-H™ Vaginal Cream** (Female BHRT) **(BioMax)**	**Estradiol 0.01% + Hyaluronic Acid 0.3% Vaginal Cream (BioMax™)** **CIRCLE QTY**: **30gms** – or – **90gms** **Sig:** Fill applicator to 1gm and insert slowly into vagina once daily.
[ ] **Estriol-H™ Vaginal Cream** (Female BHRT) **(BioMax)**	**Estriol 0.05% + Hyaluronic Acid 0.3% Vaginal Cream (BioMax™)** **CIRCLE QTY**: **30gms** – or – **90gms** **Sig:** Fill applicator to 1gm and insert slowly into vagina once daily.

SECTION D – PRESCRIBER PLEASE COMPLETE, SIGN, AND DATE:

Prescribers Name (Print) & Signature:		**Auto-Ship Refills:** PRN (Include Auto-Ship Discount) or Other ___	
Street:	City:	State:	Zip:
NPI:	DEA:	Phone:	Fax:

MedLab Pharmacy

[Fax To: 954-606-5260]

Telephone: 954-400-0560 **Fax To: 954-606-5260**

COMPOUND DRUG - PAYMENT OPTIONS

Payment Total Includes: Preparation Cost + Tamper-Resistant Shipping Cost

PAYMENT OPTIONS: Mark [X] next to your payment preference, complete form and fax with order.

1. [ ] Charge the first order **plus** all additional refills thereafter to the **patient**.

2. [ ] Charge the first order **only** to the **prescriber's office**. Charge all refills thereafter to the **patient**.

3. [ ] Charge the first order **plus** all additional refills thereafter to the **prescriber's office.**

PATIENT'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

Billing Address ____

City____ State _____ Zip________________________________

Credit Card Number____ Exp Date:___/______ CVV_____

Checking Account# ________________________________ABA (9 digits)____________________________

Authorized Signature:____

PRESCRIBER'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

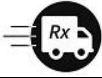
Billing Address ____

City____ State _____ Zip________________________________

Credit Card Number____ Exp Date:_____/______ CVV_____

Checking Account# ________________________________ABA (9 digits)____________________________

Authorized Signature:____

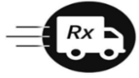


PHONE: 954-400-0560 **TREATMENT LIST #4** **FAX TO: 954-606-5260**

SECTION A – PATIENT INFORMATION:	MedLab Compounding Pharmacy		SHIP TO PATIENT
Patient Name: Male___ Female___	D.O.B:	Phone:	
Ship To Address:	City:	State:	Zip:
Drug Allergies:			

SEXUAL DYSFUNCTION – MEN & WOMEN:	
[ ] **SubDENAFIL™ Sublingual Tabs** (Erectile Dysfunction) **(BioMax)**	**Sildenafil 40mg Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **5** – or- **15** **Sig:** Dissolve one (1) tablet under the tongue 10 minutes prior to intimacy.
[ ] **SubDALAFIL™ Sublingual Tabs** (Erectile Dysfunction) **(BioMax)**	**Tadalafil 20mg Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **5** – or- **15** **Sig:** Dissolve one (1) tablet under the tongue 10 minutes prior to intimacy.
[ ] **SubTest™ (Men) Sublingual Tabs** (Men's TRT) **(CIII) (BioMax)**	**Testosterone 25mg Sublingual Tablets (BioMax™)** **QTY (30 Days Max)**: **60** (Sixty) **or Other____** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours. **Auto-Ship Refills: 5 or other____**
[ ] **Trifecta-SL™ Sublingual Tablets** (Men's TRT) **(CIII) (BioMax)**	**Testosterone 25mg + Anastrozole 0.25mg + HCG 250IU SL Tabs (BioMax™)** **Auto-Ship Refills: 5 or Other ___** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours. **QTY (30 Days Max)**: **60** (Sixty) **or Other___**
[ ] **SubTOCIN™ Sublingual Tablets** (Female Libido & Orgasm) **(BioMax)**	**Oxytocin 20iu Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **5** – or- **15** **Sig:** Dissolve one (1) tablet under the tongue 10 minutes prior to intimacy.
[ ] **Scream Cream Plus™ (BioMax)** (Female Sensitivity) **Vaginal Cream**	**Aminophylline 3% + Ergoloid Mesylate 0.1% + Pentoxifylline 5% + Sildenafil 2% - Vaginal Cream** **Sig:** Rub 2-4 pumps of cream into vagina 5-10 mins prior to intimacy. **CIRCLE QTY**: **60g** – or – **180g**

SECTION B – PRESCRIBER PLEASE COMPLETE, SIGN, AND DATE:			
Prescribers Name (Print) & Signature:	**Auto-Ship Refills:** PRN (Include Auto-Ship Discount) or Other ___		
Street:	City:	State:	Zip:
NPI:	DEA:	Phone:	Fax:



MedLab Pharmacy

[Fax To: 954-606-5260]

Telephone: 954-400-0560 **Fax To: 954-606-5260**

COMPOUND DRUG - PAYMENT OPTIONS

Payment Total Includes: Preparation Cost + Tamper-Resistant Shipping Cost

PAYMENT OPTIONS: Mark [X] next to your payment preference, complete form and fax with order.

1. [ ] Charge the first order **plus** all additional refills thereafter to the **patient**.

2. [ ] Charge the first order **only** to the **prescriber's office**. Charge all refills thereafter to the **patient**.

3. [ ] Charge the first order **plus** all additional refills thereafter to the **prescriber's office.**

PATIENT'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

Billing Address ____

City____ State _____ Zip________________________________

Credit Card Number____ Exp Date:___/______ CVV_____

Checking Account# ________________________________ABA (9 digits)____________________________

Authorized Signature:____

PRESCRIBER'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

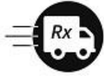
Billing Address ____

City____ State _____ Zip________________________________

Credit Card Number____ Exp Date:_____/______ CVV_____

Checking Account# ________________________________ABA (9 digits)____________________________

Authorized Signature:____



PHONE: 954-400-0560 | **TREATMENT LIST #5** | **FAX TO: 954-606-5260**

SECTION A – PATIENT INFORMATION	MedLab Compounding Pharmacy	SHIP TO PATIENT

Patient Name: Male___ Female___	D.O.B:	Phone:	
Ship To Address:	City:	State:	Zip:
Drug Allergies:			

WEIGHT-LOSS – DIET PROGRAM, APPETITE SUPRESSION, BODY COMPOSITION:

Product	Description
[ ] **SubTROPIN-12™ Sublingual Tabs** (Diet Supplement) **(BioMax)**	**HCG 250iu + B12 1000mcg Sublingual Tablets (BioMax™)** **CIRCLE QTY: 30** – or – **90** **Sig**: Dissolve one (1) tablet under the tongue once daily in the morning.
[ ] **SubMORELIN 2+6™ SL Tablets** (Body Composition, Muscle, Fat) **(BioMax)**	**Sermorelin + GHRP 2 + GHRP 6 (200/100/100mcg) Sublingual Tablets (BioMax™)** **Sig**: Dissolve one (1) tablet under the tongue once daily before bedtime. **CIRCLE QTY: 30** – or – **90**
[ ] **Phenterimine-SL™ SL Tablets** (Breakthrough Hunger) **(CIV) (BioMax)**	**Phentermine 10mg Sublingual Tablets** **QTY (30 Days Max): 60 (Sixty) or Other ____** **Sig:** Dissolve one (1) tab SL 1-3 times daily prn breakthrough hunger. **Auto-Ship Refills: 5 or other____**
[ ] **PhenTopimate-SL™ SL Tablets** (Breakthrough Hunger) **(CIV) (BioMax)**	**Phentermine 10mg + Topiramate 30mg Sublingual Tablet** **QTY (30 Days Max): 30 (Thirty) or Other ____** **Sig:** Dissolve one (1) tab under the tongue once daily in the morning **Auto-Ship Refills: 5 or other____**

THYROID - NATURAL REPLACEMENT THERAPY (NDT):

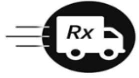
Product	Description
[ ] **Thyroid-SL™ Sublingual Tabs** (Natural Thyroid) **(BioMax)**	**Thyroid, (USP) 20mg Sublingual Tablets (BioMax™)** **CIRCLE QTY: 30** – or – **90** **Sig**: Dissolve one 1-2 tablets under the tongue every morning.

DIABETES – NEUROPATHY, MICRO-CIRCULATION, DIABETIC TOES:

Product	Description
[ ] **GlucoDERM™ Transdermal Gel** (Neuropathy/Micro-Circulation) **(BioMax)**	**Pentoxifylline 5% + Gabapentin 5% + Lidocaine 5% + Ketoprofen 5% (Micellized) TransDermal Gel** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **(BioMax™)** **CIRCLE QTY: 60g** - or - **180g**
[ ] **NeuroDERM™ Transdermal Gel** (Neuropathic Pain) **(BioMax)**	**Gabapentin 5% + Lidocaine 6%+ Bupivacaine 2% + Ketoprofen 10% (Micellized) Transdermal Gel** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **(BioMax™)** **CIRCLE QTY: 60g** - or - **180g**
[ ] **NifediFylline™ Transdermal Gel** (Circulation) **(BioMax)**	**Nifedipine 10% + Pentoxifylline 10% (Micellized) Transdermal Gel (BioMax™)** **Sig**: Rub 1-2 pumps full into affected area 3 to 4 times daily. **CIRCLE QTY: 60gms** - or – **180gms**
[ ] **NeuroToe™ Transdermal Gel** (Diabetic Toes) **(BioMax)**	**Bupivacaine 2% + Gabapentin 6% + Clonidine 0.2% + Nifedipine 2% (Micellized) TransDermal Gel** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **(BioMax™)** **CIRCLE QTY: 60gms** - or – **180gms**

SECTION B: PRESCRIBER PLEASE COMPLETE, SIGN, AND DATE:

Prescribers Name (Print) & Signature:		**Auto-Ship Refills:** PRN (Include Auto-Ship Discount) or Other ___	
Street:	City:	State:	Zip:
NPI:	DEA:	Phone:	Fax:



MedLab Pharmacy

[Fax To: 954-606-5260]

Telephone: 954-400-0560 **Fax To: 954-606-5260**

COMPOUND DRUG - PAYMENT OPTIONS

Payment Total Includes: Preparation Cost + Tamper-Resistant Shipping Cost

PAYMENT OPTIONS: Mark [X] next to your payment preference, complete form and fax with order.

1. [ ] Charge the first order **plus** all additional refills thereafter to the **patient**.

2. [ ] Charge the first order **only** to the **prescriber's office**. Charge all refills thereafter to the **patient**.

3. [ ] Charge the first order **plus** all additional refills thereafter to the **prescriber's office.**

PATIENT'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

Billing Address ____

City____ State _____ Zip________________________________

Credit Card Number____ Exp Date:___/______ CVV_____

Checking Account# ________________________________ABA (9 digits)____________________________

Authorized Signature:____

PRESCRIBER'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

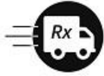
Billing Address ____

City____ State _____ Zip________________________________

Credit Card Number____ Exp Date:_____/______ CVV_____

Checking Account# ________________________________ABA (9 digits)____________________________

Authorized Signature:____



PHONE: 954-400-0560 **TREATMENT LIST #6** **FAX TO: 954-606-5260**

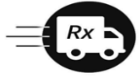
SECTION A – PATIENT INFORMATION:	MedLab Compounding Pharmacy		SHIP TO PATIENT
Patient Name: Male___ Female___	D.O.B.	Phone:	
Ship To Address:	City:	State:	Zip:
Drug Allergies:			

PAIN MANAGEMENT – BACK, NECK, LEG CRAMPS, SURGICAL PAIN, NEUROPATHIES, MUSCLE SPASMS:

Product	Formula / Sig
[ ] **PainDERM™ Transdermal Gel** (Chronic Pain & Injury) **(BioMax)**	**Cyclobenzaprine 3% + Baclofen 3% + Ketoprofen 6% + Lidocaine 5% + Bupivacaine 3% (Micellized)** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **Transdermal Gel** **CIRCLE QTY**: **60g** – or – **180g**
[ ] **NeuroDERM™ Transdermal Gel** (Neuropathic Pain) **(BioMax)**	**Gabapentin 5% + Lidocaine 10% + Ketoprofen 5% (Micellized) Transdermal Gel (BioMax™)** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **CIRCLE QTY**: **60g** – or – **180g**
[ ] **ArthroDERM™ Transdermal Gel** (Neuropathic Pain) **(BioMax)**	**Ketoprofen 15% (Micellized) + Lidocaine 10% + Transdermal Gel (BioMax™)** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **CIRCLE QTY**: **60g** – or – **180g**
[ ] **MeloxiTram-SL™ SL Tablets** (Chronic Pain) **(CIV) (BioMax)**	**Meloxicam 7.5mg + Tramadol 30mg Sublingual Tablets** **QTY (30 Days Max)**: **60 (Sixty) or Other ____** **Sig**: Dissolve 1 tab under the tongue Q12H for chronic pain. **Auto-Ship Refills: 5 or Other____**
[ ] **TramaTriptyline-SL™ SL Tablets** (Chronic Pain) **(CIV) (BioMax)**	**Tramadol 30mg + Amitriptyline 12.5mg Sublingual Tabs** **QTY (30 Days Max)**: **60 (Sixty) or Other ____** **Sig**: Dissolve 1 tab under the tongue every 12 hours for chronic pain. **Auto-Ship Refills: 5 or Other____**
[ ] **SubTram-NX™ Sublingual Tabs** (Breakthrough Pain) **(CIV) (BioMax)**	**Tramadol 30mg + Naloxone 0.25mg Sublingual Tablets** **QTY (30 Days Max)**: **90 (Ninety) or Other ____** **Sig**: Dissolve one (1) tablet under the tongue Q3-4H prn breakthrough pain. **Auto-Ship Refills: 5 or Other____**
[ ] **CrampDERM™ Transdermal Gel** (Leg Cramps/Muscle Spasms) **(BioMax)**	**Guaifenesin 10% + Magnesium Chloride 10% (Micellized) Transdermal Gel (BioMax™)** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **CIRCLE QTY**: **60g** – or – **180g**
[ ] **SubTREXONE™ (LDN) SL Tablets** (Pain, Autoimmune, Inflammation) **(BioMax)**	**Naltrexone 1.5mg (LDN) Sublingual Tablets (BioMax™)** **Sig**: Dissolve one (1) tablet under the tongue once daily before bedtime. **CIRCLE QTY**: **30** - or - **90**

SECTION B – PRESCRIBER PLEASE COMPLETE, SIGN, AND DATE:

Prescribers Name (Print) & Signature:		**Auto-Ship Refills:** PRN (Include Auto-Ship Discount) or Other ___	
Street:	City:	State:	Zip:
NPI:	DEA:	Phone:	Fax:



MedLab Pharmacy

[Fax To: 954-606-5260]

Telephone: 954-400-0560 **Fax To: 954-606-5260**

COMPOUND DRUG - PAYMENT OPTIONS

Payment Total Includes: Preparation Cost + Tamper-Resistant Shipping Cost

PAYMENT OPTIONS: Mark [X] next to your payment preference, complete form and fax with order.

1. [ ] Charge the first order **plus** all additional refills thereafter to the **patient**.

2. [ ] Charge the first order **only** to the **prescriber's office**. Charge all refills thereafter to the **patient**.

3. [ ] Charge the first order **plus** all additional refills thereafter to the **prescriber's office.**

PATIENT'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

Billing Address ____

City_________________________________ State _____ Zip___________________________

Credit Card Number____________________________________ Exp Date:___/______ CVV_____

Checking Account# ___________________________ABA (9 digits)________________________

Authorized Signature:____

PRESCRIBER'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

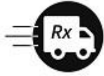
Billing Address ____

City_________________________________ State _____ Zip___________________________

Credit Card Number__________________________________ Exp Date:_____/______ CVV_____

Checking Account# ___________________________ABA (9 digits)________________________

Authorized Signature:____



PHONE: 954-400-0560 | **TREATMENT LIST #7** | **FAX TO: 954-606-5260**

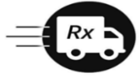
SECTION A – PATIENT INFORMATION:	MedLab Compounding Pharmacy		SHIP TO PATIENT
Patient Name: Male___ Female___	D.O.B:	Phone:	
Ship To Address:	City:	State:	Zip:
Drug Allergies:			

DERMATOLOGY – HAIR-LOSS (MEN & WOMEN), ATOPIC DERMATITIS, MICRO-CIRCULATION, FACIAL AGING:

[ ] **BioMax-M™ Hair-Loss Formula** (Worlds #1 Formula For Men) **(BioMax)**	**Minoxidil 15% + Finasteride 0.1% + Tretinoin 0.025% (Micronized) Topical Hair-Formula (For Men)** **Sig**: Spray and rub 1-2 pumps full into the affected areas on scalp twice daily. **CIRCLE QTY**: **60ml** - or - **180ml**
[ ] **BioMax-W™ Hair-Loss Formula** (Worlds #1 Formula For Women) **(BioMax)**	**Minoxidil 5% + Azelaic Acid 5% + Tretinoin 0.025% (Micronized) Topical Hair-Formula (For Women)** **Sig**: Spray and rub 1-2 pumps full into the affected areas on scalp twice daily. **CIRCLE QTY**: **60ml** - or - **180ml**
[ ] **PentoxyDerm™ Topical Ointment** (Atopic Dermatitis, Eczema)	**Pentoxifylline 10% (Micronized) Topical Ointment (BioMax™)** **Sig**: Rub 1-2 pumps full into affected area 3 to 4 times daily. **CIRCLE QTY**: **60g** - or - **180g**
[ ] **TriPentoDerm™ Topical Ointment** (Atopic Dermatitis, Eczema) **(BioMax)**	**Triamcinolone 0.1% + Pentoxifylline 10% (Micronized) Topical Ointment (BioMax™)** **Sig**: Rub 1-2 pumps full into affected area 3 to 4 times daily. **CIRCLE QTY**: **60gm** - or – **180gm**
[ ] **PsoriaDerm™ Topical Ointment** (Psoriasis) **(BioMax)**	**Naltrexone 0.5% + Pentoxifylline 5% (Micronized) Topical Ointment (BioMax™)** **Sig**: Rub 1-2 pumps full into affected area 3 to 4 times daily. **CIRCLE QTY**: **60gm** - or – **180gm**
[ ] **PsoriaDerm-Plus™ Topical Ointment** (Psoriasis) **(BioMax)**	**Naltrexone 0.5% + Pentoxifylline 5% + Triamcinolone 0.1% (Micronized) Topical Ointment** **Sig**: Rub 1-2 pumps full into affected area 3 to 4 times daily. **CIRCLE QTY**: **60gm** - or – **180gm**
[ ] **UlcerDerm™ Topical Ointment** (Skin Ulcers) **(BioMax)**	**Misoprostol 0.0024% + Nifedipine 2% + Phenytoin Sodium 5% (Micronized) Topical Ointment** **Sig**: Rub 1-2 pumps full into affected area 3 to 4 times daily. **(BioMax™)** **CIRCLE QTY**: **60gm** - or – **180gm**
[ ] **DecubiDerm™ Topical Ointment** (Decubitus Ulcers) **(BioMax)**	**Lidocaine 2% + Misoprostol 0.003% + Phenytoin 2.5% (Micronized) Topical Ointment** **Sig**: Rub 1-2 pumps full into affected area 3 to 4 times daily. **CIRCLE QTY**: **60gm** - or – **180gm**
[ ] **ProEstraDerm-10™ Facial Cream** (Facial Aging) **(BioMax)**	**Estradiol 0.01% + Estriol 0.3% + Progesterone 2% + CoQ10 0.3% + Tretinoin 0.025% Facial Cream** **Sig:** Massage 1-2 pumps full gently into the facial skin twice daily. **(BioMax™)** **CIRCLE QTY**: **60gm** -or- **180g**m
[ ] **Shingles-Relief™ Topical Gel** (Shingles, Pain Relief) **(BioMax)**	**Acyclovir 5% + Gabapentin 5% + Lidocaine 5% + Ketoprofen 5% (Micellized) Topical Gel (BioMax™)** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **CIRCLE QTY**: **60g** - or – **180g**
[ ] **GlucoDERM™ Transdermal Gel** (Neuropathy & Micro-Circulation) **(BioMax)**	**Pentoxifylline 5% + Gabapentin 5% + Lidocaine 5% + Ketoprofen 5% (Micellized) TransDermal Gel** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **(BioMax™)** **CIRCLE QTY**: **60g** - or - **180g**

SECTION B – PRESCRIBER PLEASE COMPLETE, SIGN, AND DATE:

Prescribers Name (Print) & Signature:		**Auto-Ship Refills:** PRN (Include Auto-Ship Discount) or Other ___	
Street:	**City:**	**State:**	**Zip:**
NPI:	**DEA:**	**Phone:**	**Fax:**



MedLab Pharmacy

[Fax To: 954-606-5260]

Telephone: 954-400-0560 **Fax To: 954-606-5260**

COMPOUND DRUG - PAYMENT OPTIONS

Payment Total Includes: Preparation Cost + Tamper-Resistant Shipping Cost

PAYMENT OPTIONS: Mark [X] next to your payment preference, complete form and fax with order.

1. [ ] Charge the first order **plus** all additional refills thereafter to the **patient**.

2. [ ] Charge the first order **only** to the **prescriber's office**. Charge all refills thereafter to the **patient**.

3. [ ] Charge the first order **plus** all additional refills thereafter to the **prescriber's office.**

PATIENT'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

Billing Address ____

City_________________________________ State _____ Zip___________________________

Credit Card Number____________________________________ Exp Date:___/______ CVV_____

Checking Account# ___________________________ABA (9 digits)______________________

Authorized Signature:____

PRESCRIBER'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

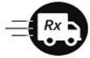
Billing Address ____

City_________________________________ State _____ Zip___________________________

Credit Card Number__________________________________ Exp Date:_____/______ CVV_____

Checking Account# ___________________________ABA (9 digits)______________________

Authorized Signature:____

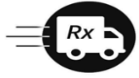


PHONE: 954-400-0560 | **TREATMENT LIST #8** | FAX TO: 954-606-5260

SECTION A – PATIENT INFORMATION:	MedLab Compounding Pharmacy		SHIP TO PATIENT
Patient Name: Male___ Female___	D.O.B:	Phone:	
Ship To Address:	City:	State:	Zip:
Drug Allergies:			

EAR, NOSE & THROAT – FOR SPRAYS, DROPS, NEBULIZERS, NETIPOT, SQUEEZE BOTTLES, IRRIGATORS	
[ ] Acetylcyst InstaMix™ Caps (Mucolytic) (BioMax™)	**Acetylcysteine 200mg InstaMix Capsules (BioMax™)** **Sig**: Empty contents into liquid and use at bedside as directed. **CIRCLE QTY**: 50 - or – 200
[ ] Ampho-B InstaMix™ Caps (Sinusitis) (BioMax™)	**Amphotericin-B 5mg 200mg InstaMix Capsules (BioMax™)** **Sig**: Empty contents into liquid and use at bedside as directed. **CIRCLE QTY**: 50 - or – 200
[ ] TobraBud InstaMix™ Caps (Sinusitis) (BioMax™)	**Tobramycin 125mg + Budesonide 0.6mg InstaMix Capsules (BioMax™)** **Sig**: Empty contents into liquid and use at bedside as directed. **CIRCLE QTY**: 50 - or – 200
[ ] BudPirocin InstaMix™ Caps (Sinusitis) (BioMax™)	**Budesonide 0.6mg + Mupirocin 30mg InstaMix Capsules (BioMax™)** **Sig**: Empty contents into liquid and use at bedside as directed. **CIRCLE QTY**: 50 - or – 200
[ ] CMF InstaMix™ Caps (Sinusitis) (BioMax™)	**Clindamycin 150mg + Mupirocin 75mg + Fluticasone 3mg InstaMix Capsules (BioMax™)** **Sig**: Empty contents into liquid and use at bedside as directed. **CIRCLE QTY**: 50 - or – 200
[ ] LIB InstaMix™ Caps (Sinusitis) (BioMax™)	**Levofloxacin 100mg + Itraconazole 40mg + Budesonide 0.6mg InstaMix Capsules (BioMax™)** **Sig**: Empty contents into liquid and use at bedside as directed. **CIRCLE QTY**: 50 - or – 200
[ ] VancoMetasone InstaMix™ Caps (Allergic Rhinitis) (BioMax™)	**Vancomycin 160mg + Mometasone 0.6mg InstaMix Capsules (BioMax™)** **Sig**: Empty contents into liquid and use at bedside as directed. **CIRCLE QTY**: 50 - or – 200
[ ] LMF InstaMix™ Caps (Allergic Rhinitis) (BioMax™)	**Levocetirizine 2mg + Montelukast 3mg + Fluticasone 3mg InstaMix Capsules (BioMax™)** **Sig**: Empty contents into liquid and use at bedside as directed. **CIRCLE QTY**: 50 - or – 200

SECTION B – PRESCRIBER PLEASE COMPLETE, SIGN, AND DATE:			
Prescribers Name (Print) & Signature:	Auto-Ship Refills: PRN (Include Auto-Ship Discount) or Other ___		
Street:	City:	State:	Zip:
NPI:	DEA:	Phone:	Fax:



MedLab Pharmacy

[Fax To: 954-606-5260]

Telephone: 954-400-0560 **Fax To: 954-606-5260**

COMPOUND DRUG - PAYMENT OPTIONS

Payment Total Includes: Preparation Cost + Tamper-Resistant Shipping Cost

PAYMENT OPTIONS: Mark [X] next to your payment preference, complete form and fax with order.

1. [ ] Charge the first order **plus** all additional refills thereafter to the **patient**.

2. [ ] Charge the first order **only** to the **prescriber's office**. Charge all refills thereafter to the **patient**.

3. [ ] Charge the first order **plus** all additional refills thereafter to the **prescriber's office.**

PATIENT'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

Billing Address ____

City____ State _____ Zip__________________________________

Credit Card Number____ Exp Date:___/______ CVV_____

Checking Account# _________________________________ABA (9 digits)_____________________________

Authorized Signature:____

PRESCRIBER'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

Billing Address ____

City____ State _____ Zip__________________________________

Credit Card Number____ Exp Date:_____/______ CVV_____

Checking Account# _________________________________ABA (9 digits)_____________________________

Authorized Signature:____

PHONE: 954-400-0560 **TREATMENT LIST #9** **FAX TO**: 954-606-5260

SECTION A – PATIENT INFORMATION:	MedLab Compounding Pharmacy		SHIP TO PATIENT
Patient Name: Male___ Female___	D.O.B:		Phone:
Ship To Address:	City:	State:	Zip:
Drug Allergies:			

RHEUMATOLOGY - ARTHRITIS AND BURSITIS:

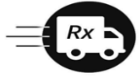
[ ] **ArthroDERM™ Transdermal Gel** (Arthritis/Bursitis, Inflammation) **(BioMax)**	**Ketoprofen 10% + Lidocaine 5% + Bupivacaine 5% (Micellized) Transdermal Gel (BioMax™)** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **CIRCLE QTY**: **60g** - or - **180g**
[ ] **SubTREXONE™ (LDN) SL Tablets** (Pain, Autoimmune, Inflammation) **(BioMax)**	**Naltrexone 1.5mg (LDN) Sublingual Tablets (BioMax™)** **Sig**: Dissolve one (1) tablet under the tongue once daily before bedtime. **CIRCLE QTY**: **30** - or - **90**
[ ] **Tramadol-SL™ Sublingual Tabs** (Breakthrough Pain) **(CIV) (BioMax)**	**Tramadol 30mg Sublingual Tablets** **QTY (30 Days Max)**: **30 (Thirty) or Other ____** **Sig**: Dissolve one (1) tablet under the tongue Q3-4H prn breakthrough pain. **Auto-Ship Refills: 5 or Other___**
[ ] **MeloxiTRAM-SL™ SL Tablets** (Chronic Pain) **(CIV) (BioMax)**	**Meloxicam 7.5mg + Tramadol 30mg Sublingual Tablets** **QTY (30 Days Max)**: **30 (Thirty) or Other ____** **Sig**: Dissolve 1 tab under the tongue Q12H as needed for chronic pain. **Auto-Ship Refills: 5 or Other___**

AUTOIMMUNE DISORDERS – PAIN, INFLAMMATION, IMMUNE FUNCTION

[ ] **SubTREXONE™ (LDN) SL Tabs** (Pain, Autoimmune, Inflammation) **(BioMax)**	**Naltrexone 1.5mg (LDN) Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **30** - or - **90** **Sig**: Dissolve one (1) tablet under the tongue once daily before bedtime.

SECTION B – PRESCRIBER PLEASE COMPLETE, SIGN, AND DATE:

Prescribers Name (Print) & Signature:		**Auto-Ship Refills:** PRN (Include Auto-Ship Discount) or Other ___	
Street:	**City:**	**State:**	**Zip:**
NPI:	**DEA:**	**Phone:**	**Fax:**



MedLab Pharmacy

[Fax To: 954-606-5260]

Telephone: 954-400-0560 **Fax To: 954-606-5260**

COMPOUND DRUG - PAYMENT OPTIONS

Payment Total Includes: Preparation Cost + Tamper-Resistant Shipping Cost

PAYMENT OPTIONS: Mark [X] next to your payment preference, complete form and fax with order.

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2. [ ] Charge the first order **only** to the **prescriber's office**. Charge all refills thereafter to the **patient**.

3. [ ] Charge the first order **plus** all additional refills thereafter to the **prescriber's office.**

PATIENT'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

Billing Address ____

City____ State _____ Zip________________________________

Credit Card Number____ Exp Date:___/______ CVV_____

Checking Account# ________________________________ABA (9 digits)____________________________

Authorized Signature:____

PRESCRIBER'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

Billing Address ____

City____ State _____ Zip________________________________

Credit Card Number____ Exp Date:_____/______ CVV_____

Checking Account# ________________________________ABA (9 digits)____________________________

Authorized Signature:____

PHONE: 954-400-0560 | **TREATMENT LIST #10** | **FAX TO: 954-606-5260**

SECTION A – PATIENT INFORMATION: | **MedLab Compounding Pharmacy** | **SHIP TO PATIENT**

Patient Name: Male___ Female___	D.O.B:	Phone:	
Ship To Address:	City:	State:	Zip:
Drug Allergies:			

MIGRAINE HEADACHE – HEAD PAIN, NAUSEA & VOMITTING:

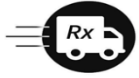
[ ] **Prochlorperazine-SL Tabs™** (Migraine, Nausea, Vomiting) **(BioMax)**	**Prochlorperazine 5mg Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **10** - or - **30** **Sig**: Dissolve 1-2 tablets under the tongue at onset, then 1 every 30 mins as needed. (Max 6 in 24 hours.)
[ ] **Prochlor-Plus™ Sublingual Tabs** (Migraine Pain) **(CIV)** **(BioMax)**	**Prochlorperazine 5mg + Tramadol 30mg Sublingual Tabs** **QTY (30 Days Max)**: **10 (Ten) or Other ____** **Sig** Dissolve 1-2 tabs SL at onset, then 1 q30mins prn. (Max 6 in 24 hours.) **Auto-Ship Refills: 5 or Other____**
[ ] **Sumatryptine-SL Tabs™** (Migraine Headache) **(BioMax)**	**Sumatryptine 20mg Tablets (BioMax™)** **CIRCLE QTY**: **10** – or – **30** **Sig**: Dissolve 1-2 tablets under the tongue at onset, may repeat in 2 hours as needed. (Max 4 in 24 hours.)
[ ] **Sumatryptine-Plus SL Tabs™** (Migraine Headache) **(BioMax)**	**Sumatryptine 20mg + Prochlorperazine 5mg Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **10** – or – **30** **Sig**: Dissolve 1-2 tablets under the tongue at onset, may repeat in 2 hours as needed. (Max 4 in 24 hours.)

SLEEP AND ANXIETY – INSOMNIA, STRESS:

[ ] **TrazaTONIN™ Sublingual Tab** (Insomnia Relief) **(BioMax)**	**Trazadone 30mg + Melatonin 10mg Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **60** – or – **180** **Sig**: Dissolve 1-2 tablets under the tongue before bedtime.
[ ] **BuspiroZine™ Sublingual Tab** (Stress & Anxiety) **(BioMax)**	**Buspirone 5mg + Hydroxyzine HCL 10mg Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **60** – or – **180** **Sig**: Dissolve 1 tablet under the tongue 2-3 times daily as needed.

SECTION C: PRESCRIBER PLEASE COMPLETE, SIGN, AND DATE:

Prescribers Name (Print) & Signature:		Auto-Ship Refills: PRN (Include Auto-Ship Discount) or Other ___	
Street:	City:	State:	Zip:
NPI:	DEA:	Phone:	Fax:



<u>MedLab Pharmacy</u>

[Fax To: 954-606-5260]

Telephone: 954-400-0560 **Fax To: 954-606-5260**

<u>COMPOUND DRUG - PAYMENT OPTIONS</u>

Payment Total Includes: Preparation Cost + Tamper-Resistant Shipping Cost

<u>PAYMENT OPTIONS: Mark [X] next to your payment preference, complete form and fax with order.</u>

1. [ ] Charge the <u>first order</u> **plus** <u>all</u> additional refills thereafter to the **patient**.

2. [ ] Charge the <u>first order</u> **only** to the **prescriber's office**. Charge <u>all</u> refills thereafter to the **patient**.

3. [ ] Charge the <u>first order</u> **plus** <u>all</u> additional refills thereafter to the **prescriber's office.**

<u>PATIENT'S PAYMENT METHOD:</u> Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

Billing Address ____

City__________________________________ State _____ Zip_____________________________

Credit Card Number_____________________________________ Exp Date:___/______ CVV_____

Checking Account# ___________________________ABA (9 digits)_________________________

Authorized Signature:____

<u>PRESCRIBER'S PAYMENT METHOD</u>: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

Billing Address ____

City__________________________________ State _____ Zip_____________________________

Credit Card Number___________________________________ Exp Date:_____/______ CVV_____

Checking Account# ___________________________ABA (9 digits)_________________________

Authorized Signature:____

PHONE: 954-400-0560

TREATMENT LIST #11

FAX TO: 954-606-5260

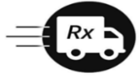
SECTION A – PATIENT INFORMATION:	MedLab Compounding Pharmacy		SHIP TO PATIENT
Patient Name: Male___ Female___	D.O.B:	Phone:	
Ship To Address:	City:	State:	Zip:
Drug Allergies:			

PODIATRY – GOUT, DIABETIC TOES & MICRO-CIRCULATION, FOOT PAIN, NEUROPATHIES:

[ ] **GoutRelief™ Transdermal Gel** (Gout, Pain Relief) **(BioMax)**	**Colchicine 0.06% + Indomethacin 10% + Allopurinol 5% + Lidocaine 5% (Micellized) TransDermal Gel** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **CIRCLE QTY**: **60g** - or - **180g** **(BioMax™)**
[ ] **GlucoDERM™ Transdermal Gel** (Neuropathy & Micro-Circulation) **(BioMax)**	**Pentoxifylline 5% + Gabapentin 5% + Lidocaine 5% + Ketoprofen 5% (Micellized) TransDermal Gel** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **(BioMax™)** **CIRCLE QTY**: **60g** - or - **180g**
[ ] **NeuroToes™ Transdermal Gel** (Diabetic Toes) **(BioMax)**	**Bupivacaine 2% + Gabapentin 6% + Clonidine 0.2% + Nifedipine 2% (Micellized) TransDermal Gel** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **(BioMax™)** **CIRCLE QTY**: **60gms** - or – **180gms**
[ ] **PainDERM™ Transdermal Gel** (Chronic Pain & Injury) **(BioMax)**	**Cyclobenzaprine 3% + Baclofen 3% + Ketoprofen 6% + Lidocaine 5% + Bupivacaine 3% (Micellized)** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **Transdermal Gel** **CIRCLE QTY**: **60g** – or – **180g**
[ ] **NeuroDERM™ Transdermal Gel** (Neuropathic Pain) **(BioMax)**	**Gabapentin 5% + Lidocaine 10% + Ketoprofen 5% (Micellized) Transdermal Gel (BioMax™)** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **CIRCLE QTY**: **60g** – or – **180g**

SECTION C: PRESCRIBER PLEASE COMPLETE, SIGN, AND DATE:

Prescribers Name (Print) & Signature:		**Auto-Ship Refills**: PRN (Include Auto-Ship Discount) or Other ___	
Street:	City:	State:	Zip:
NPI:	DEA:	Phone:	Fax:



MedLab Pharmacy

[Fax To: 954-606-5260]

Telephone: 954-400-0560 **Fax To: 954-606-5260**

COMPOUND DRUG - PAYMENT OPTIONS

Payment Total Includes: Preparation Cost + Tamper-Resistant Shipping Cost

PAYMENT OPTIONS: Mark [X] next to your payment preference, complete form and fax with order.

1. [ ] Charge the first order **plus** all additional refills thereafter to the **patient**.

2. [ ] Charge the first order **only** to the **prescriber's office**. Charge all refills thereafter to the **patient**.

3. [ ] Charge the first order **plus** all additional refills thereafter to the **prescriber's office.**

PATIENT'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

Billing Address ____

City____________________________________ State _____ Zip______________________________

Credit Card Number____ Exp Date:___/______ CVV_____

Checking Account# ______________________________ABA (9 digits)__________________________

Authorized Signature:____

PRESCRIBER'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

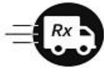
Billing Address ____

City____________________________________ State _____ Zip______________________________

Credit Card Number______________________________________ Exp Date:_____/______ CVV_____

Checking Account# ______________________________ABA (9 digits)__________________________

Authorized Signature:____

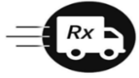


PHONE: 954-400-0560 **TREATMENT LIST #12** **FAX TO**: 954-606-5260

SECTION A – PATIENT INFORMATION:	MedLab Compounding Pharmacy		SHIP TO PATIENT
Patient Name: Male___ Female___	D.O.B:	Phone:	
Ship To Address:	City:	State:	Zip:
Drug Allergies:			

VARIOUS – VERTIGO, NAUSEA & VOMITTING, SMOKING CESSATION, ANAPHYLAXIS:	
[ ] **Scopolamine-SL Tabs™ (BioMax)** (Vertigo, Motion/Travel Sickness, Nausea)	**Scopolamine 0.4mg (Fast-Acting) Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **10** – or – **30** **Sig**: Dissolve one (1) tablet under the tongue every 3-4 hours as needed.
[ ] **Prochlorperazine-SL Tabs™** (Migraine, Nausea, Vomiting) **(BioMax)**	**Prochlorperazine 5mg Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **10** - or - **30** **Sig**: Dissolve 1-2 tablets under the tongue at onset, then 1 every 30 mins as needed. (Max 6 in 24 hours.)
[ ] **CigRelief™ Sublingual Tablets** (Smoking Cessation) **(BioMax™)**	**Nicotine 2mg Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **100** – or – **300** Sig: Dissolve one 1 tablet under the tongue every 3-4 hours as needed to abort cravings.
[ ] **EpiSTAT™ Sublingual Tablets** (Anaphylaxis) **(BioMax™)**	**Epinephrine 20mg Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **4** –or- **12** **Sig**: Dissolve 1 (*for kids) or 2 (for adults) tablet(s) under the tongue at onset. (*Kids 13+yo and 99+ lbs)
[ ] **EpiSTAT-Plus™ Sublingual Tabs** (Anaphylaxis) **(BioMax™)**	**Epinephrine 20mg + Diphenhydramine 25mg Sublingual Tablets (BioMax™)** **CIRCLE QTY**: **4** –or- **12** **Sig**: Dissolve 1 (*for kids) or 2 (for adults) tablet(s) under the tongue at onset. (*Kids 13+yo and 99+ lbs)
[ ] **CetiraSone InstaMix™ Caps** (Allergic Rhinitis) **(BioMax™)**	**Levocetirizine 2mg + Fluticasone 3mg InstaMix Capsules (BioMax™)** **Sig**: Empty contents into liquid and use at bedside as directed. **CIRCLE QTY**: **60 - or – 180**
1. Name Of Custom Compound	A. Ingredients, Strengths, Dosage Form, Quantity, Sig: B. Refills PRN (Include Auto-Ship Discount) or Other ______
2. Name Of Custom Compound	A. Ingredients, Strengths, Dosage Form, Quantity, Sig: B. Refills PRN (Include Auto-Ship Discount) or Other ______

SECTION B: PRESCRIBER PLEASE COMPLETE, SIGN, AND DATE:			
Prescribers Name (Print) & Signature:		**Auto-Ship Refills**: PRN (Include Auto-Ship Discount) or Other ___	
Street:	City:	State:	Zip:
NPI:	DEA:	Phone:	Fax:



MedLab Pharmacy

[Fax To: 954-606-5260]

Telephone: 954-400-0560 **Fax To: 954-606-5260**

COMPOUND DRUG - PAYMENT OPTIONS

Payment Total Includes: Preparation Cost + Tamper-Resistant Shipping Cost

PAYMENT OPTIONS: Mark [X] next to your payment preference, complete form and fax with order.

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3. [ ] Charge the first order **plus** all additional refills thereafter to the **prescriber's office.**

PATIENT'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

Billing Address ____

City_______________________________________ State _____ Zip__________________________________

Credit Card Number____ Exp Date:___/______ CVV_____

Checking Account# __________________________________ABA (9 digits)____________________________

Authorized Signature:____

PRESCRIBER'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account ____

Billing Address ____

City_______________________________________ State _____ Zip__________________________________

Credit Card Number____ Exp Date:_____/______ CVV_____

Checking Account# __________________________________ABA (9 digits)____________________________

Authorized Signature:____