

PEPTIDES - NON-STERILE

Clinic Name	
Address	
Phone	

Prescriber		NPI/DEA	
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- ☐ New Patient (if new, please include address and phone number with DOB)
- ☐ Existing Patient (if existing, only DOB required unless information changed)

Patient Name		DOB	
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Patient Address	
Patient Phone	

Allergy: _____ Dye-free capsule (extra fee)

<input type="checkbox"/> Ship to Clinic	<input type="checkbox"/> Ship to Patient	<input type="checkbox"/> Patient Pick-up	<input type="checkbox"/> Bill Patient	<input type="checkbox"/> Bill Clinic
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Drug Name	Form	Strength	Drug Name	Form	Strength
<input type="checkbox"/> 5-AMINO-1MQ (MEHTYLQUINOLINE)	CAPSULE	50mg	<input type="checkbox"/> NAD+ (6mL)	NASAL SPRAY	300mg
<input type="checkbox"/> NMN (NICOTINAMIDE MONONUCLEOTIDE)	CAPSULE	100mg	<input type="checkbox"/> NAD+ (10mL)	NASAL SPRAY	300mg
<input type="checkbox"/> METHYLENE BLUE	CAPSULE	8mg	<input type="checkbox"/> GHK-CU (30mL)	SOLUTION	5mg/mL
<input type="checkbox"/> METHYLENE BLUE	CAPSULE	50mg	<input type="checkbox"/> GHK-CU (30gm)	CREAM	5mg/gm
<input type="checkbox"/> PENTADECAPEPTIDE ARGINATE (PDA)	CAPSULE	1mg	<input type="checkbox"/> TRIPLE THREAT (LIDOCAINE-HYDROCORTISONE-PDA)	CREAM	4-1-0.015%
<input type="checkbox"/> PENTADECAPEPTIDE ARGINATE (PDA)	CAPSULE	0.5mg	<input type="checkbox"/> RAPAMYCIN	CAPSULE	3mg
<input type="checkbox"/> PENTADECAPEPTIDE ARGINATE (PDA)	CREAM	0.15mg/ gm	<input type="checkbox"/> RAPAMYCIN	CAPSULE	6mg
<input type="checkbox"/> TESOFENSINE	CAPSULE	500mcg	<input type="checkbox"/> RAPAMYCIN	CAPSULE	9mg

Directions: _____ Qty: _____ Refills: _____

Authorized Person: _____ Date: _____

Signature: _____