SEXUAL HEALTH

Clinic Name	
Address	
Phone	

Prescriber		NPI/DEA	

☐ 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	

Patient Address	
Patient Phone	

☐ Include syringes (extra fee) Allergy: _____

☐ Ship to Clinic	☐ Ship to Patient	☐ Patient Pick-up	☐ Bill Patient	☐ Bill Clinic

Drug Name	Form	Strength
☐ *"LIBIDO" CREAM (THEOPHYLLINE-ARGININE-NIACINAMIDE)*	CREAM	2.4%-6%-1%
☐ *"O-CREAM" (PAPAVERINE-SILDENAFIL)*	CREAM	2%-2%
☐ *OXYTOCIN*	NASAL SPRAY	50IU/mL
☐ *PT-141 (BREMELANOTIDE) (6mL)*	NASAL SPRAY	5mg/mL
☐ *PT-141 (BREMELANOTIDE) (2mL)*	INJECTION	10mg/mL
☐ *OXYTOCIN*	TROCHE	20IU/mL
☐ *"MAX PERFORMANCE" (TADALAFIL-SILDENAFIL-APOMORPHINE-B-12)*	TROCHE	20mg-40mg-3mg-2mg
☐ *"MAX PERFORMANCE" (TADALAFIL-SILDENAFIL-APOMORPHINE-B-12)*	TROCHE	40mg-80mg-3mg-2mg
☐ *"MAX PERFORMANCE" (TADALAFIL-SILDENAFIL-APOMORPHINE-B-12)*	SUBLINGUAL	20mg-40mg-3mg-2mg
☐ *SILDENAFIL*	TROCHE	STRENGTH:____mg
☐ *TADALAFIL*	TROCHE	STRENGTH:____mg

Directions: _____Qty: _____ Refills:_____

Authorized Person: _____ Date: _____

Signature:_____

PRINT CLEAR FORM