TOPICAL ANESTHETICS

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	

Allergy: _____

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

Drug Name	Strength	Drug Name	Strength
☐ *BENZOCAINE-LIDOCAINE-TETRACAINE*	20-10-10%	☐ *BENZOCAINE-LIDOCAINE-TETRACAINE*	20-10-4%
☐ *BENZOCAINE-LIDOCAINE-TETRACAINE*	20-20-20%	☐ *BENZOCAINE-LIDOCAINE-TETRACAINE*	28-8-8%
☐ *LIDOCAINE-TETRACAINE-PRILOCAINE*	20-10-20%	☐ *LIDOCAINE-TETRACAINE-PRILOCAINE*	23-7-2.5%
☐ *LIDOCAINE*	25%	☐ *LIDOCAINE-TETRACAINE*	23-7%
☐ *LIDOCAINE-TETRACAINE-PHENYLEPHRINE*	23-7-2%	☐ *LIDOCAINE-TETRACAINE-PRILOCAINE-PHENYLEPHRINE*	20-10-20-2%
☐ *BENZOCAINE-LIDOCAINE-TETRACAINE-DMSO* ***CREAM***	20-20-10-10%	☐ *BENZOCAINE-LIDOCAINE-TETRACAINE-PRILOCAINE*	20-10-10-8%
☐ *NIFEDIPINE* ***OINTMENT***	0.20%	☐ *KETOPROFEN-LIDOCAINE-GABAPENTIN* ***CREAM***	10-5-5%
☐ *NIFEDIPINE-LIDOCAINE* ***OINTMENT***	0.2-4%	☐ *NITROGLYCERIN-LIDOCAINE-TETRACAINE* ***OINTMENT***	0.1-5-0.5%

☐ **CREAM (30 GRAMS)**	☐ **OINTMENT (30 GRAMS)**

Don't see your strength? Call us to request a custom formulation (additional fee may apply)

Sig: _____Qty: _____ Refills:_____

Authorized Person: _____Date: _____

Signature:_____

PRINT **CLEAR FORM**