Prescription Order Form

CLARK PROFESSIONAL PHARMACY
Intergrative Pharmacy Since 1980

Please Fax to: (734) 585-5184 or Call in to: (734) 369-8782
3280 Washtenaw Ave. Suite B, Ann Arbor, MI 48104

PCAB ACCREDITED® Compounding Pharmacy

Patient Information:

PLEASE FAX: Patient Demographic Sheet & Prescription Insurance Card if available.

FIRST NAME:	LAST NAME:	DATE OF BIRTH:
PRIMARY PHONE #:	SECONDARY PHONE #:	DRIVER'S LICENSE (if CII, CIII or CIV):
ADDRESS:	CITY, STATE, ZIP:	ALLERGIES:

Rx Medication Order:

Pharmacist Please Compound:

Prescriber: You may change the directions, or delete / substitute / add any additional medications for all formulations.

☐ BiMix AP 20-1	☐ BiMix AP 40-1	☐ BiMix 15-0.5	☐ BiMix 30-1	☐ BiMix 30-1.5
Alprostadil 20mcg/ml Phentolamine 1mg/ml	Alprostadil 40mcg/ml Phentolamine 1mg/ml	Papaverine 15 mg/ml Phentolamine 0.5 mg/ml	Papaverine 30 mg/ml Phentolamine 1 mg/ml	Papaverine 30 mg/ml Phentolamine 1.5 mg/ml
Qty _____ Refill _____	Qty _____ Refill _____	Qty _____ Refill _____	Qty _____ Refill _____	Qty _____ Refill _____
☐ TriMix 30-1-5	☐ TriMix 30-1-10	☐ TriMix 30-1-20	☐ TriMix 30-1-40	☐ Quad 30-1-40-0.1
Papaverine 30 mg/ml Phentolamine 1 mg/ml Alprostadil 5 mcg/ml	Papaverine 30 mg/ml Phentolamine 1 mg/ml Alprostadil 10 mcg/ml	Papaverine 30 mg/ml Phentolamine 1 mg/ml Alprostadil 20 mcg/ml	Papaverine 30 mg/ml Phentolamine 1 mg/ml Alprostadil 40 mcg/ml	Papaverine 30 mg/ml Phentolamine 1 mg/ml Alprostadil 40 mcg/ml Atropine 0.1 mg/ml
Qty _____ Refill _____	Qty _____ Refill _____	Qty _____ Refill _____	Qty _____ Refill _____	Qty _____ Refill _____

☐ Papaverine ________ mg/ml
Phentolamine ________ mg/ml
Alprostadil ________ mcg/ml
Atropine ________ mg/ml

☐ 50 Unit (0.5 cc) 30g 5/16 inch syringes

☐ 100 Unit (1 cc) 30g 5/16 inch syringes

☐ SIG

(OPTIONAL) ADDITIONAL INSTRUCTIONS OR COMPOUNDS:

Prescriber Information:

PRESCRIBER'S SIGNATURE:

NPI# or DEA# (CTP# for CNPs only):

DATE:

Contact Information: