FAX Cover Sheet

From: _____ **Date:_____**

Fax #:_____ **Phone #:_____**

To: Mixtures Pharmacy
Fax: 480-706-0489

- ☐ Ahwatukee (Phone: 480-706-0620)
- ☐ Gilbert (Phone: 480-300-5279)
- ☐ Scottsdale (Phone: 480-400-0649)

Subject: New Rx
Pages: (including the cover sheet) #_____

Comments:

Patient Name: _____ DOB:_____/_____/_____

Address:_____ City_____State_____Zip_____

Phone: (_____)_____-_____ Allergies:_____

Formulary

	Medication/Dose (*Must write Testosterone if intended to be in the prescription)	Directions	Supply	Refills
CREAMS	**Formulary Creams:** Come in the following strengths in a pump (4 pumps = 1gm) in our standard base. If you or the patient requests a different delivery device or base, the medication is outside the formulary pricing.			
	Progesterone ▢**10% 100mg/gm**	Apply ▢ 1/4 ▢1/2 ▢ 3/4 ▢1 pump topically daily to inner thigh/inner arm, alternating sites	▢45gm ▢90gm	
	T_____ ▢**20% 200mg/gm** (*Must write Testosterone if intended to be in the prescription)	Apply ▢ 1/4 ▢1/2 ▢ 3/4 ▢1 pump topically daily to inner thigh/inner arm, alternating sites	▢45gm ▢90gm	

		Medication/Dose *Flavor choices available as non-formulary*	Directions	Supply	Refills
CAPSULE	TROCHE	**Progesterone ▢50mg ▢75mg ▢150mg ▢225mg IR capsule**	▢Take 1 capsule ▢at bedtime ▢bid	▢#90	
		Progesterone ▢75mg ▢100mg ▢200mg MR capsule	▢Take 1 capsule ▢at bedtime ▢bid	▢#90	
		Progesterone ▢200mg troche	▢Dissolve ▢ 1/4 ▢1/2 ▢ 3/4 ▢1 troche sl ▢ qhs ▢bid ▢tid	▢#30 ▢#90	
		T_____ **▢100mg troche** (*Must write Testosterone if intended to be in the prescription)	▢Dissolve ▢ 1/4 ▢1/2 ▢ 3/4 ▢1 troche sl ▢ daily ▢bid ▢tid	▢#30 ▢#90	

Nothing in or beyond this box.

Signature (substitution permissible)	Printed Name	DEA (if Testosterone)	Office Phone	Date

Patient Name: _____ DOB:_____/_____/_____

Address:_____ City_____State_____Zip_____

Phone: (_____)_____-_____ Allergies:_____

Non-Formulary

	Medication/Dose (*Must write Testosterone if intended to be in the prescription)	Directions [For ease of application, dose will be concentrated into ½ gram of cream]	Supply	Refills
CREAMS	**T_____ _____mg/dose** (typical dose = 5-50mg) (*Must write Testosterone if intended to be in the prescription)	Apply (dose) daily to back of calf/ inner thigh/ inner arm, alternating sites	▢30 days ▢60 days ▢90 days	
	Progesterone _____mg/dose (typical dose = 0.5-5mg)			
	T_____ _____mg/dose (*Must write Testosterone if intended to be in the prescription) **Progesterone _____mg/dose** **DHEA**(1-2.5mg) **_____mg/dose** **Pregnenolone**(1-2mg)**_____mg/dose** **Anastrazole**(0.005-0.15mg)**____mg/dose**			

		Medication/Dose	Form	Directions [May write alternate sig]	Supply	Refills
CAPSULE	**Or TROCHE**	**T_____ _____mg/troche** (typical dose = 2-5 mg) (*Must write Testosterone if intended to be in the prescription)	▢Troche	▢Take 1 dose daily at bedtime or Dissolve ½ troche sl ▢qhs ▢bid	▢30 days ▢60 days ▢90 days	
		Progesterone _____mg/cap/troche (typical dose = 5-20mg)	▢MR ▢IR ▢Troche ▢Commercial gel cap			
		T_____ _____mg/dose (*Must write Testosterone if intended to be in the prescription) **Progesterone _____mg/dose** **DHEA** (5-25mg) **_____mg/dose** **Pregnenolone**(10-20mg)**_____mg/dose**	▢MR ▢IR ▢Troche			

	Medication/Dose	Directions	Supply	Refills
Injection	**T_____ Cypionate 200mg/ml** (*Must write Testosterone to complete this rx) *Commercial	Inject ____ml IM every ▢____ days ▢14 days ▢10 days ▢7 days	▢_____ml ▢10ml	

	Medication/Dose [Aromatase Inhibitor suggested if elevated estrogen levels or pt is stressed and/or overweight]	Directions	Supply	Refills
MISC	▢**Clomiphene Citrate 50mg tablet** *Commercial	Take ½ tablet three times weekly		
	▢**Anastrozole 1mg tablet** *Commercial	Take ½ tablet twice weekly		
	▢**HCG 10,000u/10ml**(typical dose 500-1500u) *Commercial	Inject _____units sq three times weekly	1 box	
	▢**Clomiphene/DHEA/7KetoD/P4/Anastrozole** 20/20/20/20/ ▢0.03mg ▢0.05mg ▢0.1mg	Take 1 capsule daily	▢#30 ▢#60 ▢#90	

Signature (substitution permissible)	Printed Name	DEA (if Testosterone)	Office Phone	Date