



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:

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Patient Name: _____ DOB: ____/____/____
 Address: _____ City _____ State _____ Zip _____
 Phone: (____) _____ - _____ Allergies: _____

Formulary

	Medication/Dose <small>(*Must write Testosterone if intended to be in the prescription)</small>	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 <small>(*Must write Testosterone if intended to be in the prescription)</small>	Apply □ 1/4 □1/2 □ 3/4 □1 pump topically daily to inner thigh/inner arm, alternating sites	□45gm □90gm	

	Medication/Dose <small>*Flavor choices available as non-formulary*</small>	Directions	Supply	Refills
CAPSULE	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 <small>(*Must write Testosterone if intended to be in the prescription)</small>	□Dissolve □ 1/4 □1/2 □ 3/4 □1 troche sl □ daily □bid □tid	□#30 □#90	

Nothing in or beyond this box.

Signature <small>(substitution permissible)</small>	Printed Name	DEA (if Testosterone)	Office Phone	Date
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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
C R E A M S	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		<input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 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 Anastrozole (0.005-0.15mg) _____ mg/dose				

		Medication/Dose	Form	Directions [May write alternate sig]	Supply	Refills
C A P S U L E	or	T _____ mg/troche (typical dose = 2-5 mg) (*Must write Testosterone if intended to be in the prescription)	<input type="checkbox"/> Troche	<input type="checkbox"/> Take 1 dose daily at bedtime or Dissolve ½ troche sl <input type="checkbox"/> qhs <input type="checkbox"/> bid	<input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days	
	R	Progesterone _____ mg/cap/troche (typical dose = 5-20mg)	<input type="checkbox"/> MR <input type="checkbox"/> IR <input type="checkbox"/> Troche <input type="checkbox"/> Commercial gel cap			
	S	T _____ mg/dose (*Must write Testosterone if intended to be in the prescription)	<input type="checkbox"/> MR <input type="checkbox"/> IR			
	C H E	Progesterone _____ mg/dose DHEA (5-25mg) _____ mg/dose Pregnenolone (10-20mg) _____ mg/dose	<input type="checkbox"/> Troche			

		Medication/Dose	Directions	Supply	Refills
Injection	T _____ Cypionate 200mg/ml (*Must write Testosterone to complete this rx) *Commercial	Inject _____ ml IM every <input type="checkbox"/> _____ days <input type="checkbox"/> 14 days <input type="checkbox"/> 10 days <input type="checkbox"/> 7 days	<input type="checkbox"/> _____ ml <input type="checkbox"/> 10ml		

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

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