MILLERS
a yourlifeRx company

PHARMACY COMPOUNDING ACCREDITATION BOARD

NABP Accredited Compounding Pharmacy

678 WYCKOFF AVE
WYCKOFF NJ 07481
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ANALGESIC ORDER FORM

PATIENT INFORMATION

FIRST NAME: LAST NAME:

PRIMARY PHONE #: ◯ CELL ◯ HOME ◯ WORK SECONDARY PHONE #: ◯ CELL ◯ HOME ◯ WORK

ADDRESS: CITY, STATE, ZIP: ALLERGIES:

MEDICATIONS

☐ Baclofen 10% / Ketoprofen 10%	Lipoderm ◯ 90gm or _____
☐ Baclofen 15% / Ketoprofen 20% / Lidocaine 5%	Lipoderm ◯ 90gm or _____
☐ Baclofen 2%	Lipoderm ◯ 90gm or _____
☐ Baclofen 5% / Ketoprofen 10%	Lipoderm ◯ 90gm or _____
☐ Baclofen 5% / Lidocaine 5% / ◯ Capsaicin .075% or _____%	Cream ◯ 90gm or _____
☐ Clonidine ◯ 0.2% / ◯ 0.1% / ◯ 0.02%	Lipoderm ◯ 90gm or _____
☐ Diclofenac 3%-10% _____%	Transdermal Cream ◯ 90gm or _____
☐ Diclofenac 3% / Cyclobenzaprine 0.5% / Gabapentin 6% / Lidocaine 2%	Lipoderm ◯ 90gm or _____
☐ Gabapentin 2% / Clonidine 0.1% / Lidocaine 5%	Lipoderm ◯ 90gm or _____
☐ Gabapentin ◯ 5% / ◯ 8% / ◯ 10%	Lipoderm ◯ 90gm or _____
☐ Gabapentin 5% / Ketoprofen 5% / Amitriptyline 2% / Tetracaine 1% / Deoxy-D-Glucose 0.2%	Cream ◯ 90gm or _____
☐ Gabapentin 6% / Clonidine 0.2% / Lidocaine 5%	Lipoderm ◯ 90gm or _____
☐ Ibuprofen 2.5% / Ketoprofen 10%	◯ Lipoderm / ◯ Roll-On / ◯ Spray ◯ 90gm or _____
☐ Ketoprofen 10% / Amitriptyline 2% / Carbamazepine 2%	Lipoderm ◯ 90gm or _____
☐ Ketoprofen 10% / Capsaicin 0.1% or _____%	Lipoderm ◯ 90gm or _____
☐ Ketoprofen 10% / Gabapentin 2% / Methylsalicylate 20%	Cream ◯ 90gm or _____
☐ Ketoprofen ◯ 10% / ◯ 20%	◯ Roll-On / ◯ Spray ◯ 90gm or _____
☐ Ketoprofen 10% / Baclofen 2% / Gabapentin 5% / Lidocaine 5%	Transdermal Cream ◯ 90gm or _____
☐ Ketoprofen ◯ 4% / ◯ 8% / ◯ 10% / ◯ 20%	◯ Lipoderm / ◯ Clear Gel ◯ 90gm or _____
☐ Lidocaine 4%	Isotonic Nasal Spray ◯ 90gm or _____
☐ **Low Dose Naltrexone 1mg – 7 MG IR Caps (1 cap at bedtime)** _____	◯ #30 or _____

THE FORMULATIONS BELOW REQUIRE WRITTEN PRESCRIPTIONS

☐ Ketamine Mini Troche _____mg	◯ #30 or _____
☐ Ketamine 5% / Gabapentin 10% / Clonidine 0.2% / Baclofen 2%	◯ 90gm or _____
☐ Other	Transdermal Cream _____

SIG

☐ Creams / Gels / Lotions Massage in well t.i.d.
☐ Spray / Roll-On t.i.d.

☐ Capsules / Tablets / Lozenges Take one _____ time(s) daily.
☐ Other: _____

Refills: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ PRN ◯ NR SIG: _____

WRITE PRESCRIPTION / ADDITIONAL COMMENTS

DOCTOR	PHONE	NPI #	DEA #
OFFICE MANAGER	**PHONE**	**OFFICE FAX**	**OFFICE Email**
SIGNATURE		**DATE** (Month / Day / Year)	
		_____/_____/_____	

FAX TO 201-891-1312
email to: orders@yourliferx.com