

PATIENT INFORMATION	
Patient Name: _____	Patient SSN#: _____
Address: _____ <small style="text-align: center;">Address, City, State, Zip Code</small>	
Phone #: _____	2 nd Phone #: _____
Date of Birth: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Weight (lbs): _____ Height (in.): _____ Allergies: _____	
Primary Insurance: _____	Secondary Insurance: _____
ID#: _____	Phone #: _____
ID#: _____	Phone #: _____
FAX COPY OF INSURANCE CARD (FRONT & BACK)	

MEDICATION	COMPOSITION	APPLY ON AFFECTED AREA OF	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> KETOPROFEN 10% TOPICAL LIPODERM	Ketoprofen 10% PCCA Lipoderm QS 100 g	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID	<input type="checkbox"/> 100 g	
<input type="checkbox"/> CETYL MYRISTOLEATE 2% TOPICAL LIPODERM	Cetyl Myristoleate 2% PCCA Lipoderm QS 80 g	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID	<input type="checkbox"/> 100 g	
<input type="checkbox"/> KETAMINE 5% / GABAPENTIN 10% / CLONIDINE HCL 0.2% / BACLOFEN 2% TOPICAL LIPODERM	Ketamine 5% Gabapentin 10% Clonidine HCL 0.2% Baclofen 2% PCCA Lipoderm QS 30 mL	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID	<input type="checkbox"/> 30 mL	
<input type="checkbox"/> DICLOFENAC SODIUM 1% TOPICAL LIPODERM	Diclofenac Sodium 1% PCCA Lipoderm QS 100 g	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID	<input type="checkbox"/> 100 g	
<input type="checkbox"/> EMLA / GABAPENTIN 10% / CLONIDINE HCL 0.2% / BACLOFEN 2%	EMLA 30 g Gabapentin 10% Clonidine HCL 0.2% Baclofen USP 2%	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID <input type="checkbox"/> QID	<input type="checkbox"/> 30 g	

PHYSICIAN INFORMATION	
Physician Name: _____	Contact: _____
NPI#: _____	
Address: _____ <small style="text-align: center;">Address, City, State, Zip Code</small>	
Phone #: _____	Fax#: _____
Email: _____	
Physician's Signature: _____	
Date: _____	
<input type="checkbox"/> Dispense As Written	
I AUTHORIZE DELTA DRUGS AND ITS REPRESENTATIVES TO ACT AS AN AGENT TO INITIATE AND EXECUTE THE INSURANCE PRIOR AUTHORIZATION PROCESS.	
I ALSO UNDERSTAND THAT THE FDA DOES NOT REVIEW ANY COMPOUNDED MEDICATION FOR SAFETY OR EFFICACY.	