



PATIENT NAME _____ PATIENT DOB _____

ALLERGIES _____ DIAGNOSIS _____

DAY PHONE _____ CELL PHONE _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PRESCRIBER NAME _____

PHONE _____ FAX _____

NPI _____ DEA _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

TRANSDERMAL ACTIVE INGREDIENTS

NMDA-CA CHANNEL BLOCKER

KETAMINE (5-10%): _____%

GABA-B AGONIST

BACLOFEN (1-2%): _____%

ALPHA-2 AGONIST

CLONIDINE (1-2%): _____%

OPIOID ANTAGONIST

NALTREXONE (1-5%): _____%

OPIOID ANTAGONIST-AGONIST

BUPRENORPHINE (1-5%): _____%

CALCIUM CHANNEL BLOCKER

NIFEDIPINE (1-2%): _____%

TRICYCLIC ANTIDEPRESSANTS

AMITRIPTYLINE (1-10%): _____%

IMIPRAMINE (1-10%): _____%

DOXEPIN (1-5%): _____%

CYCLOBENZAPRINE (1-5%): _____%

ANESTHETIC

BENZOCAINE (1-10%): _____%

LIDOCAINE (1-10%): _____%

TETRACAINE (1-5%): _____%

BUPIVACAINE (0.25-5%): _____%

NA-GLUTAMATE BLOCKER

GABAPENTIN (5-10%): _____%

PREGABALIN (1-5%): _____%

NSAIDS

KETOPROFEN (1-10%): _____%

DICLOFENAC (1-10%): _____%

MELOXICAM (1-5%): _____%

FLURBIPROFEN (1-10%): _____%

PIROXICAM (1-5%): _____%

OTHER

MAGNESIUM (1-10%): _____%

CARBAMAZEPINE (1-5%): _____%

MENTHOL (1-2%): _____%

CAPSAICIN (0.01-0.025%): _____%

CBD (0.5-10%): _____%

DEXTROMETHORPHAN (1-5%): _____%

_____%
INGREDIENT

TRANSDERMAL BASES

VERSA CREAM LIPO CREAM PAIN BASE CREAM CELL CODE CBD CREAM OTHER: _____

TRANSDERMAL DEVICE

PUMP: 0.25 mL/Pump 0.5 mL/Pump 1 mL/Pump TUBE OTHER: _____

TRANSDERMAL CREAMS DIRECTIONS

DIRECTIONS: Apply 1-2 grams to affected area(s) every 4 hours as needed for pain.

ALTERNATIVE DIRECTIONS: _____

QUANTITY

30 gm 60 gm 120 gm

REFILL(S) _____

PRESCRIBER AUTHORIZATION

PRESCRIBER SIGNATURE _____

DATE _____

SUBSTITUTIONS PERMITTED

DISPENSE AS WRITTEN