



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 _____

INJECTABLE PRODUCTS

ALPROSTADIL
40 mcg/mL

BIMIX 30:1
Papaverine 30 mg/mL
Phentolamine 1 mg/mL

TRIMIX 10:20:1
Alprostadil 10 mcg/mL
Papaverine 20 mg/mL
Phentolamine 1 mg/mL

TRIMIX 10:30:1
Alprostadil 10 mcg/mL
Papaverine 30 mg/mL
Phentolamine 1 mg/mL

QUADMIX 10:30:1:400
Alprostadil 10 mcg/mL
Papaverine 30 mg/mL
Phentolamine 1 mg/mL
Atropine 400 mcg/mL

CUSTOM ORDER
Alprostadil: _____ mcg/mL
Papaverine: _____ mg/mL
Phentolamine: _____ mg/mL
Atropine: _____ mg/mL

PHENYLEPHRINE 1 mg/mL
DIRECTIONS
Inject 10 units intracavenosally every 3-5 minutes as needed for prolonged erection. Maximum dose is 1 mg over 1 hour.
QUANTITY: One 1 mL vials **REFILLS:** _____

ALPROSTADIL-BIMIX-TRIMIX DIRECTIONS
 Inject _____ units intracavenosally 15 minutes prior to sexual activity. Do not inject on consecutive days. No more than three injects per week. Titrate per provider.
QUANTITY:
 Two 2.5 mL vials Four 2.5 mL vials Other: _____ mL
REFILLS: _____

BREMELANOTIDE
BREMELANOTIDE 5 MG/ML (2.5 ML VIAL)
DIRECTIONS
 Inject 5 to 30 units under the skin 60 minutes prior to sexual activity. Do not inject on consecutive days. No more than 3 injections per week.
QUANTITY: One 2.5 mL vials Two 2.5 mL vials
REFILLS: _____

INJECTABLE SUPPLIES

INSULIN SYRINGES-10 SYRINGES PER BAG
 0.3 mL 31 guage 5/16 inch Insulin Syringe
 0.5 mL 31 guage 5/16 inch Insulin Syringe
 1 mL 31 guage 5/16 inch Insulin Syringe
QUANTITY: _____ Bags **REFILLS:** _____

MISCELLANEOUS SUPPLIES
 Sharps Container
 Alcohol Wipes

PRESCRIBER AUTHORIZATION

PRESCRIBER SIGNATURE _____ DATE _____

SUBSTITUTIONS PERMITTED

DISPENSE AS WRITTEN