AHI EFax: (888) 553-5425

You may select one or more compounds as needed

Rx Request	Patient
Dr. Name: _____ DEA #: _____ Tel: ( )	Patient Name: _____ Address: _____ City/State/Zip: _____ Telephone: ( )

☐**BI-EST SR Capsules (Estradiol/Estriol)** Dose: 1.0mg 1.5mg 2.0mg 2.5mg Quantity:_____ SIG: Take ____ cap/s orally in the AM Refills: 1 2 3 4 other:_____	☐**Compounded Thyroid T4/T3 Capsules – SR or NON-SR** Dose: 15mg 30mg 60mg 90mg 120mg 150mg 180mg Quantity:_____ 240mg 300mg 360mg SIG: Take ____ cap/s orally in the AM Refills: 1 2 3 4 other:_____
☐**BI-EST Transdermal Cream (Estradiol/Estriol)** Dose: 1.50mg/ml 2.0mg/ml 2.5mg/ml Quantity:_____ SIG: Apply ___ ml to skin ___ time/s daily Refills: 1 2 3 4 other:_____	☐**DHEA SR Capsules** Dose: 10mg 15mg 25mg 50mg 75mg 100mg Quantity:_____ SIG: Take ____ cap/s orally in the AM Refills: 1 2 3 4 other:_____
☐**TRI-EST SR Capsules (Estriol/Estradiol/Estrone)** Dose: 1.0mg 1.5mg 2.0mg Quantity:_____ SIG: Take ____ cap/s orally in the AM Refills: 1 2 3 4 other _____	☐**MELATONIN SR Capsules** Dose: 1mg 2mg 3mg 6mg 10mg 20mg Quantity:_____ SIG: Take ____ cap/s orally at bed time Refills: 1 2 3 4 other _____
☐**TRI-EST Transdermal Cream (Estriol/Estradiol/Estrone)** Dose:1.25mg/ml 1.75mg/ml 2.0mg/ml 2.4mg/ml Quantity:_____ SIG: Apply ___ ml to skin _____ time/s daily Refills: 1 2 3 4 other _____	☐**PREGNENLONE SR Capsules** Dose: 25mg 50mg 100mg Quantity:_____ SIG: Take ___ cap/s orally _____ time/s daily Refills: 1 2 3 4 other _____
☐**PROGESTERONE SR Capsules** Dose: 50mg 100mg 150mg 200mg Quantity:_____ SIG: Take ____ cap/s orally in the PM Refills: 1 2 3 4 other _____	☐**VITAMIN D3 Capsules** Dose: 1,000 IU 5,000 IU 10,000 IU Quantity:_____ SIG: Take ___ cap/s orally _____ time/s daily Refills: 1 2 3 4 other _____
☐**PROGESTERONE Sublingual Triturate** Dose: 25mg 50mg 100mg Quantity:_____ SIG: Dissolve__ tablet under the tongue __ time/s daily Refills: 1 2 3 4 other _____	☐**ESTRIOL VAGINAL CREAM** Dose: 0.05%(0.5mg) 0.5%(5mg) 0.1%(1mg) 1%(10mg) Quantity:_____ SIG: Insert ___ ml vaginally ___ time/s per week Refills: 1 2 3 4 other _____
☐**PROGESTERONE Rapid Dissolve** Dose: 50mg 100mg 200mg Quantity:_____ SIG: Dissolve__ tablet under the tongue __ time/s daily Refills: 1 2 3 4 other _____	☐**ESTRADIOL Cream** Dose: 0.2mg 0.5mg 1.0mg 2.0mg 2.5mg Quantity:_____ SIG: Apply ___ ml to skin _____ time/s daily Refills: 1 2 3 4 other _____
☐**PROGESTERONE Transdermal Cream** Dose: 25mg/ml 50mg/ml 100mg/ml 200mg/ml Quantity:_____ SIG: Apply ___ ml to skin _____ time/s daily Refills: 1 2 3 4 other _____	☐**ARGININE/PAPAVERINE Cream** Dose: 6/0.1% mg/ml Quantity:_____ SIG: Apply ___ ml to clitoral area _____ daily Refills: 1 2 3 4 other _____
☐**ESTRADIOL/PROGESTERONE Transdermal Cream** Dose: 1mg/100mg/ml 1mg/200mg/ml 2mg/ml 200mg/ml Quantity:_____ SIG: Apply ___ ml to skin _____ time/s daily Refills: 1 2 3 4 other _____	THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES "d a w" IN THE BOX BELOW ☐ Dispense as Written

Physician Signature: _____

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Rx Request	Patient
Dr. Name: _____ DEA #: _____ Tel: ( )	Patient Name: _____ Address: _____ City/State/Zip: _____ Telephone: ( )

TESTOSTERONE & COMBIANTIONS

Women

☐**BI-EST (Estradiol/Estriol) Transdermal Cream + TESTOSTERONE**
Dose: (1.5mg+5mg testo)/ml (2.0mg+5mg testo)/ml (2.5mg+10mg testo)/ml
Quantity:_____
SIG: Apply ___ ml to skin _____ time/s daily
Not Refillable

☐**TRI-EST (Estriol/Estradiol/Estrone) Transdermal Cream + TESTOSTERONE**
Dose: (1.5mg+5mg testo)/ml (2.0mg+10mg testo)/ml (2.5mg+10mg testo)/ml
Quantity:_____
SIG: Apply ___ ml to skin _____ time/s daily
Not Refillable

☐**PROGESTERONE Transdermal Cream + TESTOSTERONE**
Dose: (50mg+5mg testo)/ml (50mg+10mg testo)/ml (100mg+5mg testo)/ml (100mg+10mg testo)/ml
Quantity:_____
SIG: Apply ___ ml to skin _____ time/s daily
Not Refillable

☐**TESTOSTERONE VANISHING Cream**
Dose: 1mg/ml 5mg/ml 10mg/ml 20mg/ml
Quantity:_____
SIG: Apply ___ ml to skin _____ time/s daily
Not Refillable

Men

☐ **TESTOSTERONE Cream**
Dose: 50mg/ml 100mg/ml 150mg/ml 200mg/ml
Quantity:_____
SIG: Apply ___ ml to skin _____ time/s daily
Not Refillable

**** NY DOCTORS PLEASE PROVIDE SERIAL#: _____ ****

PLEASE MAIL ALL ORIGINAL TESTOSTERONE PRESCRIPTONS TO PHARMACY
NY DOCTORS MUS MAIL OFFICIAL NY STATE PRESCRIPTIONS

Physician Signature: _____

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES "d a w" IN THE BOX BELOW

☐ Dispense as Written