

New Order/Prescription Fax Form



FAX NUMBER: _____

STEP 1

COMPLETE PATIENT INFO

Patient Name _____ EBM ID _____
 Cell Phone # _____ Date of Birth _____
 Email _____ MM / DD / YYYY
 Street Address _____
 City _____ State _____ Zip _____ Allergies _____

STEP 2

SELECT FORMULATION

Topical Pain Cream

Neuropathic Pain
 P2 Gabapentin 5%, Amitriptyline 3%, Clonidine 0.2%, Lidocaine 5% in Salt Stable LS Advanced Cream
Sig Apply a nickel size amount to the treatment area 1-3 times daily.
Qty 90 gms **Refills** PRN Other _____

Anti-Inflammatory Pain
 P3 Diclofenac 3%, Baclofen 2%, Lidocaine 5% in Salt Stable LS Advanced Cream
Sig Apply a nickel size amount to the treatment area 1-3 times daily.
Qty 90 gms **Refills** PRN Other _____

Neuropathic / Anti-Inflammatory Pain
 P6 Diclofenac 4%, Lidocaine 5%, Gabapentin 5%, Pentoxifylline 3%, Clonidine 0.2%, Amitriptyline 3% in Salt Stable LS Advanced Cream



Fibromatosis
 P55 Verapamil 15%, Diclofenac 3%, Lidocaine 5% Salt Stable LS Advanced Cream
90 Grams **Refills** PRN Other _____
Sig Apply a nickel size amount to the treatment area 1-3 x day

Circulation/Diabetic Toes/Raynaud's Phenomenon

T1 Nifedipine 8%, Pentoxifylline 8% Cream
SIG Apply 1-2 gm to affected area 3-4 times daily
Qty 90 gms **Refills** PRN or _____

iontophoretic Patch

4mg/mL DEXAMETHASONE for injection (2 x 5 ml vials) PLUS 6 Patches (select 1 below)

- 4 hr STAT (80mA-min) PATCH** 
- 14 hr 80 (80 mA-min) PATCH** 

Ideal Location Feet-Elbows-Knees-Wrists-Shoulders

ADD Adapta-cap Syringe 1-unit

SIG Apply per instructions every other day for prescribed amount of time.

OTHER SIG _____ **Refills** _____ PRN

Anti-Fungal Cream

N1 Amphotericin B 3%, Terbinafine 1%, Urea 20%, Thymol 4% in Recura Cream
Sig Apply to infected area once daily
Qty 30 gms **Refills** PRN Other _____

Tolcyclen

Antifungal Solution
 Active Ingredient: Tolnaftate 1% **Qty** 7.5 mls
 Antifungal Eradication Nail/Skin Renewal Kit
 Antifungal/Nail Renewal Solution (7.5 ml)
 Antifungal/Skin Renewal Cream (20 gm)
 Antifungal/Antibacterial Shoe Spray (80 ml)
Sig Apply twice per day or **Refills** PRN or
Other SIG _____ _____

Wart Formula

W1 Cimetidine 5%, 5-Fluorouracil 5%, Salicylic Acid 10%, IBU 10% in Collodion Solution
Sig Cover affected area twice daily
Qty 15 mls **Refills** PRN or _____

Hyperhidrosis

H5 Glycopyrrolate 1%, Zinc Oxide 5%, Aluminum Chloride 12% in a transdermal base
SIG Apply half pump to each foot daily or as directed by your doctor
Qty 30 gms **Refills** PRN or _____

Scar Cream

S1 Lidocaine 5%, Verapamil 5%, Pentoxifylline 0.5%, Hyaluronic Acid 0.5%, Fluticasone Propionate 0.05% in Sanare Advanced Scar Cream

Hyperpigmented

S2 Hydroquinone 4%, Fluocinolone 0.01%, Tretinoin 0.05%, Kojic Acid 6%, Lipoic Acid 3% in Sanare Advanced Scar Cream

Sig Apply to target area once daily

Qty 30 gms **Refills** PRN Other _____

STEP 3

COMPLETE PROVIDER INFO

FAX TO

HCP Name	NPI #	DEA #	HCP Name	NPI #	DEA #
<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____

Office Contact Name _____ Phone _____ Fax _____
 Address _____ City _____ State _____ Zip _____

SIGNATURE

 Signature or Stamp Acceptable

 Date

FAX: _____ | Phone: 1-844-360-4095 | Email: support@EBMmedical.com

No claims are made as to the safety, efficacy or use of these ingredients or formulations. Compound prescriptions are fulfilled by EBM Medical accredited Pharmacy. The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender at 1-636-614-0299 and destroy all copies of the original message. EBM Medical's fax system is secure and in compliance with all applicable HIPAA regulations. RX-GEN-001, Rev0, 06/11/2019



STEP 1
COMPLETE
PATIENT
INFO

Patient Name _____ EBM ID _____
 Cell Phone # _____ Date of Birth _____
 Email _____ MM / DD / YYYY
 Street Address _____
 City _____ State _____ Zip _____ Allergies _____

STEP 2
SELECT
PRODUCT

Peripheral Neuropathic Complications

EB-N3^{DR} L-Methylfolate Calcium 6mg, Methylcobalamin 4mg, Pyridoxal 5-Phosphate 70mg, Riboflavin 1.3mg
Sig 1 capsule PO QD Qty #90 Capsules (3 month supply)

EB-N5^{DR} L-Methylfolate Calcium 6mg, Methylcobalamin 4mg, Pyridoxal 5-Phosphate 70mg, Alpha Lipoic Acid 600mg, 5000 IU Vitamin D3
Sig 2 Capsules PO QD Qty #180 Capsules (3 month supply)

EB-N6^{DR} L-Methylfolate Calcium 6mg, Methylcobalamin 4mg, Pyridoxal 5-Phosphate 70mg, Alpha Lipoic Acid 600mg, Benfotiamine 300mg
Sig 2 Capsules PO QD Qty #180 Capsules (3 month supply)

REFILLS PRN or other _____ OTHER SIG _____

Arthritic Inflammation

EB-A7^{DR} Turmeric Curcumin 95% 750mg, SAM-e 600mg, Hyaluronic Acid 200mg, Boswellia Extract 65% 100mg, Hydrolyzed Type II Collagen 40mg, Bioperine 5mg
Sig 1 capsule TID w/ food Qty #270 Capsules (3 month supply)

REFILLS PRN or other _____ OTHER SIG _____

CBD

EB-C4 Cannabidiol 3% (0% THC), Beta-Caryophyllene 3%, Myrcene 3%, Arnica 2%, MSM 2% in HRT Heavy Base
 Other Ingredients: Aloe Vera, Allantoin, Black Seed Oil, Camphor, Caster Oil, Cetearyl Alcohol, Ethylhexyl Glycerin, Eucalyptus, Glyceryl Stearate, Horse Chestnut Extract, HRT Heavy™ Transdermal Base, Hydrolyzed Oat Protein, Jojoba Oil, Kaolin Clay, Peppermint, Potassium Sorbet, Propanediol, Prunella Vulgaris Extract, Rosemary Seed Extract, Silver Citrate, Stearic Acid, Zinc Oxide.
Sig Apply 1-4 times daily. Qty 100 gms

Nail and Skin

EB-L1 L-Methylfolate Calcium 0.5mg, Cyantine™ (Keratin) HNS 500mg, Biotin-D 10mg, Choline Stabilized Orthosilicic Acid 10mg, Hydrolyzed Type I Collagen 50mg
Sig 1 capsule PO QD Qty #90 Capsules (3 month supply)

REFILLS PRN or other _____ OTHER SIG _____

Bone and Soft Tissue Healing

EB-S4 Calcium Citrate 1200mg, Magnesium Bisglycinate TRAACS 500mg, 10,000 IU Cholecalciferol, Zinc Bisglycinate Chelate TRAACS 50mg
Sig 3 capsules daily with food Qty #270 Capsules (3 month supply)

REFILLS PRN or other _____ OTHER SIG _____

STEP 3
COMPLETE
PROVIDER
INFO

FAX TO

HCP Name	NPI #	DEA #	HCP Name	NPI #	DEA #
<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____

Office Contact Name _____ Phone _____ Fax _____
 Address _____ City _____ State _____ Zip _____

SIGNATURE

 Signature or Stamp Acceptable _____ Date _____