**Fax: (913) 273-1468**
**Fax: (913) 727-6337**

**Toll-Free: 1800-746-9120**

# ORDER FORM FOR HORMONE REPLACEMENTS

**Patient's Name:** ________________________ **Date of Birth:**________________________
****Patient's Address:** ________________________ **Email:**________________________
****Home Phone Number:** ________________________ ****Cell Phone Number:**________________________
**Patient's Allergies:**________________________________________________

**Prescription Signature:** ________________________________________________
**Prescriber:** ________________________ **Person Faxing:** ________________________
**DEA:** ________________________ **NPI:** ________________________
**Address:** ________________________________________________
**Phone:** ________________**Fax:** ________________**Email:**________________

****PLEASE FAX COPIES PRESCRIPTION INSURANCE CARDS**** **Required Fields

I have indicated by number(s) below, in order of preference, the medication(s) I am prescribing. The pharmacy shall dispense my first preference, unless not covered by the patient's insurance, in which case the pharmacy shall proceed in similar manner based on my order of preference. The pharmacy may dispense any drug selected below, regardless of order of preference, based on the patient's choice.

## Hormone Replacements

❑ H001: **Estradiol 1.5 mg/ml - Progesterone 150 mg/ml - Testosterone 2 mg/ml**

*Quantity Dispensed*

❑ 30ml ❑60ml ❑ 90ml ❑ Others ______ ml

❑ H002: **Estradiol 1.5 mg/ml - Progesterone 100 mg/ml - Testosterone 2 mg/ml**

*Quantity Dispensed*

❑ 30ml ❑60ml ❑ 90ml ❑ Others ______ ml

❑ H003: **Estradiol 2 mg/ml - Progesterone 150 mg/ml - Testosterone 2 mg/ml**

*Quantity Dispensed*

❑ 30ml ❑60ml ❑ 90ml ❑ Others ______ ml

*Quantity or Percentage of each ingredients can be changed on Doctor’s recommendations*

## COURSE OF THERAPY (REFILLS)

❑30 days (0 Refills) ❑60 days (1 Refills) ❑90 days (2 Refills )
❑120 days (3 Refills) ❑150 days (4 Refills) ❑180 days (5 Refills ) ❑210 days (6 Refills) ❑360 days (11 Refills)
Other:________________________________________________

❑ I AUTHORIZE THE PHARMACIST AND/OR PHARMACY STAFF TO ACT AS MY AGENT TO ACQUIRE A PRIOR AUTHORIZATION ON THIS PRESCRIPTION