



EAST: Fax: 702-791-3630 Phone: 702-791-3800
 WEST: Fax: 702-685-3636 Phone: 702-685-3800
 Mail to patient Pick-up at pharmacy

Date: _____

Name:			DOB:		
Address:		City:		State:	Zip:
Home Phone: ()		Other Phone: ()		Allergies:	
			Other Notes:		

PRESCRIPTION ORDER FORM: (circle or check items ordered, indicate dose and dosage form)

Injectible ED Treatments: Indicate formula and vial size

- | | | | | |
|--------------------------|------------------------|---------------|-------------------------------|----------------|
| <input type="checkbox"/> | TriMix #1 | (T101) | | Refills |
| | Prostaglandin (E1) | 5.9 mcg/ml | <input type="checkbox"/> 5 ml | |
| | Papaverine | 17.65 mg/ml | | |
| | Phentolamine | 0.59 mg/ml | | |
| | | | | |
| <input type="checkbox"/> | TriMix #2 | (T102) | | Refills |
| | Prostaglandin (E1) | 8.33 mcg/ml | <input type="checkbox"/> 5 ml | |
| | Papaverine | 22.5 mg/ml | | |
| | Phentolamine | 0.83 mg/ml | | |
| | | | | |
| <input type="checkbox"/> | TriMix #3 | (T103) | | Refills |
| | Prostaglandin (E1) | 10 mcg/ml | <input type="checkbox"/> 5 ml | |
| | Papaverine | 12 mg/ml | | |
| | Phentolamine | 1 mg/ml | | |
| | | | | |
| <input type="checkbox"/> | TriMix #4 | (T104) | | Refills |
| | Prostaglandin (E1) | 20 mcg/ml | <input type="checkbox"/> 5 ml | |
| | Papaverine | 30 mg/ml | | |
| | Phentolamine | 2 mg/ml | | |
| | | | | |
| <input type="checkbox"/> | TriMix #5 | (T105) | | Refills |
| | Prostaglandin (E1) | 10 mcg/ml | <input type="checkbox"/> 5 ml | |
| | Papaverine | 30 mg/ml | | |
| | Phentolamine | 1 mg/ml | | |
| | | | | |
| <input type="checkbox"/> | TriMix #6 | (T106) | | Refills |
| | Prostaglandin (E1) | 25 mcg/ml | <input type="checkbox"/> 5 ml | |
| | Papaverine | 30 mg/ml | | |
| | Phentolamine | 1 mg/ml | | |
| | | | | |
| <input type="checkbox"/> | Super TriMix #1 | (ST1) | | Refills |
| | Prostaglandin (E1) | 50 mcg/ml | <input type="checkbox"/> 5 ml | |
| | Papaverine | 30 mg/ml | | |
| | Phentolamine | 1.5 mg/ml | | |

*Sig: Inject 0.1 ml to 0.5 ml intracavernously as directed by your physician.
 Do not exceed more than one use every other day or three times per week.
 (dispense with instruction book)*

Notes / Other _____ Refills _____

PRESCRIBER SIGNATURE	PHONE / FAX	DEA
Partell Specialty Pharmacy	EAST: 5835 S. Eastern Ave., #101 Las Vegas, NV 89119 • Ph: 702-791-3800 • Fax: 702-791-3630 WEST: 8751 W. Charleston Blvd., #120 Las Vegas, NV 89117 • Ph: 702-685-3800 • Fax: 702-685-3636	