

Testosterone Pellets must be ordered using a separate form.

BHRT Pellet Implant Order Form

IMPORTANT: Compounded formulations are not available "For Office Use".

- Compounded prescription orders must be patient-specific.
- To avoid delays in processing, you must complete the patient information section for each compounded prescription.

PATIENT INFORMATION (REQUIRED):

Patient Name _____ Male / Female _____ Date of Birth _____

Patient Street Address (No PO Boxes) _____

City _____ State _____ Zip _____

Phone (Home) _____ (W / Cell) _____ Email _____

Allergies _____

Estradiol Pellets: 6mg, 10mg, 12.5mg, 15mg, 18mg, 20mg, 25mg, 37.5mg, 50mg, 75mg, 100mg **DHEA Pellets:** 25mg, 50mg
Biest (Estriol / Estradiol) Pellets: 12.5mg/12.5mg, 25mg/25mg **Pregnenolone Pellets:** 25mg, 50mg **Progesterone Pellets:** 50mg, 100mg

Date Ordered: _____ Date Needed: _____ Refills: _____

Drug	Route	Strength	Total Qty.	Directions: For Office Administration.
	Pellet Implant Subcutaneous			Insert _____ pellets, every _____ months.
	Pellet Implant Subcutaneous			Insert _____ pellets, every _____ months.
	Pellet Implant Subcutaneous			Insert _____ pellets, every _____ months.

Trocar Options	Circle Size	Quantity
Standard Stainless Steel Trocar: 3-Piece	Regular (\$199) Large (\$199)	
Premium Surgical Stainless Steel Trocar: 3-Piece	Regular (\$349) or Large (\$399)	
3-Piece Disposable Plastic Trocar Kit	Regular (\$31.84) or Large (\$36.24)	
3-Piece Stainless Steel Disposable Trocar Kit	Regular (\$38.45) or Large (\$43.94)	

PRACTITIONER INFORMATION: Circle Designation: MD DO PA NP ND

Practitioner Name (Please Print) _____ **►SIGNATURE (REQUIRED)◄**

DEA # _____ License # _____

Office Address (if first time ordering) _____ City/State/Zip _____

Phone _____ Fax _____

Contact / Faxed By _____

Delivery Address (if different from patient or practitioner address) _____ City/State/Zip _____

Place Office Address Stamp Here. (Signature Still REQUIRED.)

BILLING & SHIPPING INFORMATION:

(GA and OH Require Prior Authorization to Ship Patient Specific Prescriptions to Practitioners. OK Prohibits It Completely.)

Billing / Shipping (Please Circle Options): Bill Practitioner / Bill Patient Ship to Practitioner / Ship to Patient

CC# (M/C, Visa, AMX) _____ Exp. Date _____ Security Code _____

Name on the Credit Card _____

Bill Credit Card On File. Last 4 #'s of CC: _____ Security Code: _____

- FedEx 3 Day Express (standard Rx) FedEx 2nd Day FedEx Overnight