Updated: 8/2014

Fax Order To: _____

Testosterone Pellet Implants may no longer be ordered "For Office Use" / "Casual Sale".

Testosterone Pellet Implant Order Form

PATIENT INFORMATION (REQUIRED):

Patient Name | Male / Female | Date of Birth

Patient Street Address (No PO Boxes)

City | State | Zip

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

▶PURPOSE (REQUIRED)

Patient ID* (Required For Controlled Substances In The Following States: AL, HI, IN, KS, KY, LA, MA, MS, OK, SD)

*State Issued Driver's License # / State ID # / Social Security # / Passport # (Indicate # type.)

Allergies

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.

▶REQUIRED Indicate specific medical necessity for indicated dosage strength(s): _____

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

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

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

BILLING & SHIPPING INFORMATION:

❑ 3 Day Express (standard Rx) ❑ 2nd Day ❑ Overnight

Due to DEA regulations, all Testosterone Pellet Prescriptions will be sent directly to the patient unless the Prescription Authorization Section is filled out. GA and OH Require Prior Authorization to Ship Patient Specific Prescriptions to Practitioners. OK Prohibits It Completely.

Patient Prescription Shipping Authorization

I, _____ (Patient Name), authorize College Pharmacy to send my _____ (Prescription Drug / Dosage Form) prescription to my practitioner,

_____ (Practitioner Name) located at _____ (Print Office Address).

This authorization applies to both this and all future Testosterone Pellet Prescriptions in my name.

_____
Patient Signature / Date

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: