Prescription Order Form – For Patient Home Use

FAX TO: (888) 247-0840

menMD

Patient Name: _____ Date of Birth: _____

Patient Phone: _____ Email: _____

ERECTILE DYSFUNCTION:

INTRACAVERNOSAL INJECTION:

	Mixture	Papaverine (mg/mL)	Phentolamine (mg/mL)	PGE1 (ug/mL)
❑	**PGE1***	-	-	25
❑	**Bimix 30/2**	30	2	-
❑	**Bimix #3**	15	0.5	-
❑	**Bimix #4**	30	1	-
❑	**Trimix #5**	30	1	10
❑	**Trimix #6**	30	4	2.5
❑	**Trimix #7**	30	4	5
❑	**Trimix #8**	30	2	20
❑	**Trimix #9**	30	4	40
❑	**Bimix #10**	30	4	-
❑	**Trimix #11**	30	4	7.5
❑	**Trimix #12**	30	4	10
❑	**Trimix #13**	30	6	60
❑	**Trimix #14**	30	1	2.5
❑	**Trimix #15**	30	2	40
❑	**Trimix #16**	30	6	100

SIG: Dispense: 1 Month Supply **Qty**: ☒ 5mL **Refills:** _____

- Inject _____ units intracavernosally as instructed.
- Increase or decrease by _____units
- Maximum Dose _____ units
- May use ❑ Daily ☒ 3 - 4 times weekly

CHOOSE SYRINGE:

❑ 1cc: 31gauge x 5/16” insulin syringes Qty: 20

❑ 1cc: 29 gauge x 1/2” insulin syringes Qty: 20

***PGE1 Only:** ❑ **By checking this box, prescriber has determined PGE1 compound is medically necessary.**

INTRAURETHRAL GEL:

	Mixture	Papaverine (mg/mL)	Phentolamine (mg/mL)	PGE1 (ug/mL)
❑	**GEL**	-	4	1000
❑	**GEL**	-	10	-
❑	**GEL**	-	20	-

Qty: ☒ 15mL **Refills:** _____

SIG: Insert _____mL intraurethrally. Increase or decrease by _____mL until desired effect is achieved. Maximum dose 1 mL. May use ☒ 1x Daily

PRIAPISM RESCUE:

❑ Phenylephrine 1 mg/mL 1mg/mL **Qty**: 10mL

SIG: Inject _____ units intracavernosally for erections lasting longer than 2.5 hours. May repeat in 15 minutes if erection does not subside. May perform a total of 3 doses. Proceed to the emergency room if erection persists. **Refills:** _____

❑ Pseudoephedrine 30 mg tablet: **Qty:** 30 tablets **Refills:** _____

SIG: _____

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ERECTILE DYSFUNCTION (CONT):

PDE5 TABLETS:

❑ Sildenafil 20mg Tablet **SIG** Take 20-100mg by mouth as needed not more than once daily. **Qty** 90 tab **Refills**: _____

❑ Sildenafil 100mg Tablet **SIG** Take 100mg by mouth as needed not more than once daily. **Qty** 90 tab **Refills**: _____

Tadalafil Lozenge ❑5mg / ❑20mg **SIG** Dissolve 1 by mouth as needed not more than once daily. **Qty** 30 Lozenge **Refills**: _____

Tadalafil Tablet ❑5mg / ❑20mg **SIG** Take 1 by mouth as needed not more than once daily. **Qty** 30 tab **Refills**: _____

Custom SIG: _____

HEALTH AND WELLNESS:

❑ Finasteride Tablets ❑1mg / ❑5mg **SIG** Take 1 by mouth daily. **Qty** 30 Tablets **Refills**: _____

❑ Anastrozole Tablets ❑ 1mg **SIG** Take 1 by mouth per week. **Qty** 30 Tablets **Refills**: _____

❑ Valacyclovir ❑500mg / ❑1,000mg Tablet. Take _____tablet(s)_____

QTY: _____ **Refills:** _____

Custom SIG: _____

VERAPAMIL / PENTOXIFYLLINE:

❑ Verapamil Injection 2.5 mg/ml Dispensed in 4mL Vial (includes 27G + 5cc Syringe + 18G draw kit/vial)
SIG: Inject 1mL into lesion 4x per treatment.
QTY: (# of 4mL Vials) _____ **Refills**: _____

❑ Verapamil Cream 12% Dispensed in a 30 mL Pump Jar
SIG: Apply 0.5mL (1 Pump) 2x per day for 30 days.
QTY: (# of 30mL Jars) _____ **Refills:** _____

❑ Pentoxifylline 400 mg tablet
SIG: Take 2 to 3 tablets PO per day as directed
Qty: (# of Tablets) _____ **Refills:** _____

❑ Peyronie's Self-Assessment Tool – Device **QTY**: _____
❑ Understanding Peyronie's Disease – Book by Dr. Laurence Levine **QTY**: _____

VACUUM ERECTION DEVICE & ACCESSORIES:

❑ Manual Augusta SomaTherapy System **QTY**: _____
❑ Battery Augusta SomaTherapy System **QTY**: _____
❑ Owen Mumford Manual Vacuum Erection Device **QTY**: _____

❑ Auto Injector **QTY**: _____
❑ Sharps Container **QTY**: _____
❑ Constriction Loop **QTY**: _____
❑ Syringe Magnifier **QTY**: _____

EJACULATORY DYSFUNCTION:

❑ MYHIXEL TR DEVICE + PLAY TR APP - **QTY**: _____
❑ MYHIXEL MED DEVICE + PLAY MED APP - **QTY**: _____
❑ MyHixel Hands Free Accessory **QTY**: _____
❑ MyHixel Replacement Sleeve **QTY**: _____

❑ Oxytocin 50iu Lozenge **SIG** Dissolve 1 by mouth at time of desired orgasm. **Qty** 30 Lozenges **Refills**: _____
❑ Promescent Spray 60 spray- **QTY**: _____
❑ Promescent Spray 40 spray - **QTY**: _____
❑ Promescent Spray 20 spray - **QTY**: _____

UROLOGY OFFICE ADMINISTRATION:

❑ Mitomycin Solution 40 mg Solution (5mg/mL) Dispense 8 mL Vial **SIG:** Dilute 8 mL's mitomycin solution with sterile water to produce final concentration
QTY: (# of 8mL Vials) _____ **Refills:** _____

❑ DMSO/Lidocaine 50%/.5% (W/V) in 50mL
SIG: Instill into bladder as directed

QTY: (# of 50mL Vials) _____ **Refills:** _____

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TESTOSTERONE REPLACEMENT:	
TESTOSTERONE CYPIONATE 200mg/mL in Sesame Oil	**TESTOSTERONE GEL 50mg/mL**
❑ Inject _____mL's every _____ **Qty**: (numerical and written)_____ ❑ Needles: 18G draw + _____G_____L for injection. Qty: 30 **Refills**:_____	❑ Apply _____mL's every _____ **Qty:** (numerical and written)_____ **Refills**:_____

REQUIRED FOR TESTOSTERONE PRESCRIPTIONS

Patient Address: _____

_____

Provider Address: _____

_____

Provider DEA Number: _____

Provider Phone Number: _____

RETAIL, INJECTION ACCESSORIES, SUPPLEMENTS:	
❑ Alcohol Prep Pads **QTY**: _____ ❑ Sanitizing Spray **QTY**: _____ ❑ Auto Injector **QTY**: _____ ❑ Constriction Loop **QTY**: _____ ❑ Insul-Ease **QTY**: _____	❑ Insul-Tote **QTY**: _____ ❑ Sharps Container **QTY**: _____ ❑ N-Acetyl Cysteine 600mg **QTY**: _____ ❑ Promescent P2L Water Based Lubricant 4 oz. - **QTY**: _____ ❑ Promescent P2L Water Based Lubricant 8 oz. - **QTY**: _____

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