

Please fax to: (toll-free) 866-687-2217

Physician Information

Organization _____ Date _____
Name _____ DEA # _____ NPI# _____
Address _____ City _____ State _____ Zip _____
Phone # _____ Fax # _____ Email _____

Patient Information

Male Female

Name _____ Email _____ DOB _____
Address _____ City _____ State _____ Zip _____
Phone # _____ HIPPA Contact(s) _____

Medications _____

Allergies _____

Curvature L R U D Collagen Formation Strip / Nodule Pain 1-10 _____ Time w/condition _____

Pain and/or constriction? Yes / No Loss of length and(or) girth? Yes / No Patient has been offered counseling by a PDLabs' pharmacist regarding this prescription.
Loss of erection quality Yes / No Bottleneck and(or) indentation? Yes / No

Transdermal Verapamil 15% Gel in PDLabs' Vehicle # 062003BE for Peyronies Disease

(Compounded using proprietary formulation and mixing specifications licensed exclusively to PDLabs)

Sig: Apply 0.5mL bid using dosimeters provided by PDLabs as directed.

#90 Days (Most patients require at least 6 months of treatment)

Refills: _____ PRN NR

Physician's Signature _____ Date _____
Dispense As Written

Note: This product is protected under U.S. Utility Patent Numbers 6,031,005 and 6,353,028.

