MedLab Pharmacy

The Compounding Experts™

Telephone: 954-400-0560 **medlabpharmacy@gmail.com** **Fax To: 954-606-5260**

ANTI-AGING: PREVENTION & TREATMENT (Formula's & Protocols)

New Prescription Worksheets

DELIVERY INSTRUCTIONS

ALL ORDERS ARE SHIPPED FOR NEXT-DAY DELIVERY

(In remote locations USPS/UPS delivery may take 2 days.)

The Price of a custom preparation must be obtained after the prescription is received so it can be calculated accurately at that time of the order and quoted to the patient before the preparation is compounded and shipped.

AUTO-SHIP PROGRAM BENEFITS

In addition to receiving VIP discounted batch pricing, the purpose of our Auto-Ship Program is to provide a convenient way for patients to stay compliant with their dosage regimens.

All Auto-Ship orders are batched and shipped on a weekly basis according to their cycle fill dates. Patients must designate how often they want to receive their Medicine so they arrive one week before their run out date.

When prescriptions placed on Auto-Ship run out of refills, prescribers and patients are notified ahead of time, so patients can stay compliant with their dosage regimens before their medications run out.

PACKAGING AND SHIPPING COSTS

1. Cost for **Room-Temperature** Tamper-Resistant Packaging with Shipping: **$12.50**

2. Cost for **Cooler Plus Frozen Ice-Packs** in Tamper-Resistant Packaging with Shipping: **$22.50**

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SECTION A – PATIENT INFORMATION: **MedLab Compounding Pharmacy** **SHIP TO PATIENT**

Patient Name: **Male___ Female___**	**D.O.B:**	**Phone:**	
Ship To Address:	**City:**	**State:**	**Zip:**
Drug Allergies:		**Weight Lbs _____ Kg _____**	

AGE-REVERSAL PROTOCOL

[ ] Senolytic Capsules™	**Dasatinib 2.5mg/kg Capsules + Quercetin 25mg/kg Capsules** **Sig**: Take each medication once a week for two consecutive weeks. **CIRCLE QTY: 2 Doses Each**
[ ] Rapamycin Capsules	**Rapamycin 5mg Capsules** **Sig**: Take one capsule once a week. **CIRCLE QTY**: **4** - or - **12**
[ ] NAD+ Patch Kit™	**NAD+ 400mg/ml Sol'n + IontoPatches** **Sig**: Add 20 drops NAD+ Sol'n to (+) side of patch and 20 drops Saline to (-), Repeat every Mon, Wed & Fri. **CIRCLE QTY**: **12** - or - **36**
[ ] NAD+ Booster Tabs	**NAD+ 40mg Sublingual Tablets (BioMax™)** **Sig**: Dissolve one (1) tablet under the tongue every 12 hours. **CIRCLE QTY**: **60** - or - **180**
[ ] ActiveLife MicroTABS	**Selegiline 0.2mg (Deprenyl) + Ergoloid Mesylates 2mg SL Tabs** **Sig**: Dissolve one (1) tablet under the tongue every 12 hours. **CIRCLE QTY**: **60** - or - **180**

SECTION B – PRESCRIBER PLEASE COMPLETE, SIGN, AND DATE:

Prescribers Name (Print) & Signature:		**Auto-Ship Refills:** PRN (Include Auto-Ship Discount) or Other ___	
Street:	**City:**	**State:**	**Zip:**
NPI:	**DEA:**	**Phone:**	**Fax:**

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Drug Allergies:			

MALE HORMONE BALANCING PROTOCOL

[ ] MensBalance™ Sublingual Tablets	**Testosterone _____ mg (example 30 mg)** **Anastrozole _____ mg (example 0.25 mg)** **HCG _____ mg (example 250 iu)** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours. **QTY (30 Days Max)**: **60** (Sixty) **or Other___** **Auto-Ship Refills: 5 or Other ___**
[ ] SubMORELIN 2+6™ SL Tablets	**Sermorelin + GHRP 2 + GHRP 6 (200/100/100mcg) Sublingual Tablets (BioMax™)** **Sig**: Dissolve one (1) tablet under the tongue once daily before bedtime. **CIRCLE QTY**: **30** - or – **90**

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SECTION A – PATIENT INFORMATION:	**MedLab Compounding Pharmacy**	**SHIP TO PATIENT**

Patient Name:	**Male___ Female___**	**D.O.B:**	**Phone:**	
Ship To Address:	**City:**		**State:**	**Zip:**
Drug Allergies:				

FEMALE HORMONE BALANCING PROTOCOL

[ ] FemBalance™ Sublingual Tablets	**Estradiol _____mg (example 1.2mg)** **Estriol _____mg (example 1.8mg)** **Progesterone _____ mg (example 25mg)** **Testosterone _____ mg (example 1.25mg)** **Sig:** Dissolve one (1) tablet under the tongue every 12 hours. **QTY (30 Days Max)**: **60** (Sixty) **or Other___** **Auto-Ship Refills: 5 or Other ___**
[ ] SubMORELIN 2+6™ SL Tablets	**Sermorelin + GHRP 2 + GHRP 6 (200/100/100mcg) Sublingual Tablets (BioMax™)** **Sig**: Dissolve one (1) tablet under the tongue once daily before bedtime. **CIRCLE QTY**: **30** - or – **90**

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Ship To Address:		**City:**	**State:**	**Zip:**
Drug Allergies:			**Weight Lbs _____ Kg _____**	

WEIGHT-LOSS PROTOCOL

[ ] SubTROPIN-12™ Sublingual Tabs	**HCG 250iu + B12 1000mcg Sublingual Tablets (BioMax™)** **Sig**: Dissolve one (1) tablet under the tongue once daily in the morning. **CIRCLE QTY**: **30** – or – **90**
[ ] SubMORELIN 2+6™ SL Tablets	**Sermorelin + GHRP 2 + GHRP 6 (200/100/100mcg) Sublingual Tablets (BioMax™)** **Sig**: Dissolve one (1) tablet under the tongue once daily before bedtime. **CIRCLE QTY**: **30** – or – **90**
[ ] Phentermine-SL™ SL Tablets	**Phentermine 10mg Sublingual Tablets** **Sig:** Dissolve one (1) tab SL 1-3 times daily prn breakthrough hunger. **QTY (30 Days Max)**: **60 (Sixty) or Other ____** **Auto-Ship Refills: 5 or other____**

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Drug Allergies:			

SEXUAL DYSFUNCTION TREATMENTS

[ ] SubDENAFIL™ Sublingual Tabs	**Sildenafil 40mg Sublingual Tablets (BioMax™)** **Sig:** Dissolve one (1) tablet under the tongue 10 minutes prior to intimacy. **CIRCLE QTY**: **10** – or- **30**
[ ] SubTOCIN™ Sublingual Tablets	**Oxytocin 20iu Sublingual Tablets (BioMax™)** **Sig:** Dissolve one (1) tablet under the tongue 10 minutes prior to intimacy. **CIRCLE QTY**: **10** - or- **30**

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NPI:	DEA:	Phone:	Fax:

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Ship To Address:	City:	State:	Zip:
Drug Allergies:			

HAIR-LOSS TREATMENTS

[ ] Prescription Hair-Loss Treatment for Men™	**Minoxidil 15% + Finasteride 0.1% + Tretinoin 0.025% + Melatonin 2% + DMSO 1ml** **Sig:** Rub 2 to 4 pumps full into dry area of scalp every 12 hours. **CIRCLE QTY**: **60mls** - or – **90mls**
[ ] Prescription Hair-Loss Treatment for Women™	**Minoxidil 5% + Azelaic Acid 5% + Tretinoin 0.025% + Melatonin 2% + Progesterone 0.5% + DMSO 1ml** **Sig:** Rub 2 to 4 pumps full into dry area of scalp every 12 hours. **CIRCLE QTY**: **60mls** - or – **90mls**

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Ship To Address:	**City:**	**State:**	**Zip:**
Drug Allergies:		**Weight Lbs _____ Kg _____**	

PAIN MANAGEMENT PROTOCOL

[ ] PainDERM™ Transdermal Gel (Chronic Pain & Injury)	**Cyclobenzaprine 3% + Baclofen 3% + Ketoprofen 6% + Lidocaine 5% + Bupivacaine 3% (Micellized) Transdermal Gel (BioMax™)** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **CIRCLE QTY**: **60g** – or – **180g**
[ ] NeuroDERM™ Transdermal Gel (Neuropathic Pain)	**Gabapentin 5% + Lidocaine 10% + Ketoprofen 5% (Micellized) Transdermal Gel (BioMax™)** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **CIRCLE QTY**: **60g** – or – **180g**
[ ] ArthroDERM™ Transdermal Gel (Arthritic Pain)	**Ketoprofen 15% (Micellized) + Lidocaine 10% + Transdermal Gel (BioMax™)** **Sig**: Rub 1-2 pumps full into affected area 2 to 6 times daily. **CIRCLE QTY**: **60g** – or – **180g**
[ ] SubTram™ Sublingual Tabs (CIV) (Breakthrough Pain)	**Tramadol 40mg Sublingual Tablets (BioMax™)** **Sig**: Dissolve one (1) tablet under the tongue Q3-4H prn breakthrough pain. **QTY (30 Days Max): 60 (Sixty) or Other ____** **Auto-Ship Refills: 5 or Other____**
[ ] SubTREXONE™ (LDN) SL Tablets (Autoimmune Pain)	**Naltrexone 1.5mg (LDN) Sublingual Tablets (BioMax™)** **Sig**: Dissolve one (1) tablet under the tongue once daily before bedtime. **CIRCLE QTY**: **30** - or - **90**

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Ship To Address:	**City:**	**State:**	**Zip:**
Drug Allergies:		**Weight Lbs _____ Kg _____**	

PRESCRIPTION ORDER(S): CUSTOM COMPOUNDING WORKSHEET

1. NAME OF COMPOUND: _____ **(A) Dosage Form/Route of Admin:** _____/_____ **(B) Quantity (Numeric) #_____** (Quantity - Spell Out In Text) _____	**(D) Ingredients + Strengths:** **1.** _____ **2.** _____ **3.** _____ **4.** _____ **(E) Sig (Directions for Use):** _____ **(F) REFILLS: PRN** or other ___ **Auto-Ship Schedule:** (circle every) **30 days / 90 days / _____ days**
1. NAME OF COMPOUND: _____ **(A) Dosage Form/Route of Admin:** _____/_____ **(B) Quantity (Numeric) #_____** (Quantity - Spell Out In Text) _____	**(D) Ingredients + Strengths:** **1.** _____ **2.** _____ **3.** _____ **4.** _____ **(E) Sig (Directions for Use):** _____ **(F) REFILLS: PRN** or other ____ **Auto-Ship Delivery Schedule: (circle every) 30 days - (or) - 90 days**

SECTION B: PRESCRIBER - PLEASE COMPLETE, SIGN, AND DATE:

Prescriber Name (print):	**Signature:**		**Date:**
Street:	**City:**	**State:**	**Zip:**
NPI:	**DEA:**	**Phone:**	**Fax:**

PRICING TABLE: Compound Drugs

All Compounds Qualify for both a $30 Auto-Ship Discount and a 90 Day Supply 25% Ingredient Discount	
Compounding Fee (See Auto-Ship Discount Below)	$59 (30 Days Supply)
****** (Minus $30 Auto-Ship Discount)***	***- $30***
Auto-Ship Compounding Fee	Only $29 (30 days supply)
*Most Ingredients	$20 each (30 days supply)
**** (Minus 25% Ingredient Discount for 90 day supplies)***	***- 25%*** *(off all Ingredients)*
Controlled Substances (Ingredients)	Add $20 (one-time fee)
Refrigerated Substances (Ingredients)	Add $20 (one-time fee)
SHIPPING, HANDLING, & TAMPER RESISTANT PACKAGING COSTS	
Shipping (Room Temperature + Tamper Resistant)	$12.50 (Flat Rate)
Shipping (Ice Packed Cooler + Tamper Resistant)	$22.50 (Flat Rate)

*__Please Note__: Expensive ingredients over $20 require a custom quote.

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PAYMENT OPTIONS for COMPOUND DRUGS

Payment Total Includes: Preparation Cost + Shipping Cost

PAYMENT OPTIONS: Mark [X] next to your payment preference, complete form and fax with order.

1. [ ] Charge the first order **plus** all additional refills thereafter to the **patient**.

2. [ ] Charge the first order **only** to the **prescriber's office**. Charge all refills thereafter to the **patient**.

3. [ ] Charge the first order **plus** all additional refills thereafter to the **prescriber's office.**

PATIENT'S PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account _____

Billing Address _____

City_____ State _____ Zip_____

Credit Card Number_____ Exp Date:___/_____ CVV_____

Checking Account# _____ABA (9 digits)_____

Authorized Signature:_____

DOCTOR'S OFFICE PAYMENT METHOD: Credit Card -or- Checking Account Information

Name on Credit Card or Checking Account _____

Billing Address _____

City_____ State _____ Zip_____

Credit Card Number_____ Exp Date:_____/_____ CVV_____

Checking Account# _____ABA (9 digits)_____

Authorized Signature:_____