

**PATIENT INFORMATION**

"Valid if transmitted by facsimile machine only"

*PATIENT NAME:

*DATE OF BIRTH:

☐ Deliver to patient (Free)

SSN:

ADDRESS:

*PHONE:

CITY:

STATE:

ZIP:

ICD9 CODES/DX:

Insurance ID:

Group:

BIN:

PCN:

Allergies:

MOST REQUESTED FORMULAS

- ☐ LDN Starter Kit=(Naltrexone 1.5mg Capsule #40 & Naltrexone 0.5mg Capsule #32)

SIG: Take capsules daily prior to bedtime as per starter kit directions

- ☐ Naltrexone (LDN) 0.5 mg Capsule Quantity: 70 (1st month supply)

SIG: Start at 1 capsule (0.5 mg) at bedtime and titrate up each week by 1 capsule (0.5 mg) to desired effect or physician specified dose

- ☐ Naltrexone (LDN) ☐ 1.5mg ☐ 3mg ☐ 4.5mg ☐ ____ mg

- ☐ Naltrexone 3% Transdermal Cream Quantity: 30 grams

SIG: Apply (1-4) clicks 3 to 4 times a day to painful areas

DAYS	LDN 1.5MG	LDN 0.5MG	DOSE PER DAY
1-8	1 CAPSULE DAILY	NONE	1.5MG
9-16	1 CAPSULE DAILY	1 CAPSULE DAILY	2MG
17-24	1 CAPSULE DAILY	2 CAPSULES DAILY	2.5MG
25-32	2 CAPSULES DAILY	1 CAPSULE DAILY	3.5MG
Maintenance Dose	☐ 4.5MG	☐ 5MG	☐ ____MG

Quantity: ____ 30 Day Supply Other Quantity: ____

Sig: _____

Other Requested Formulations: _____

PRESCRIBER

Name:

TEL:

SIGNATURE: _____

DATE ____/____/____

Dispense as Written

May Substituted

FAX: (317) 900-7458

The information here is solely for reference and should not be considered as endorsing any formulations' effectiveness. These sample formulations are based on past prescriptions written by licensed professionals and are not intended to influence professional judgment.

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NOBLESVILLE PHARMACY

FAX COMPLETED PRESCRIPTION • PATIENT PHONE NUMBER

_____ **TO: (317) 900-7458** _____

NOBLESVILLE LOW COST PHARMACY • 758 Westfield Drive • Noblesville, IN 46062 • (317) 231-5252