ALLIED PHARMACY

LETTER OF PROTECTION/LIENS SCRIPT PAD

Ph: 832-365-3420 Fax: 855-595-2955

Patient Name:_____ DOB:_____ Weight:_____ ☐ Male ☐ Female
Street Address:_____
Apt #:_____ City:_____ State:_____ Zip:_____
Phone: _____ Cell:_____
Attorney:_____ DOI:_____
Phone:_____ Fax:_____

Bill to: ☐ Attorney ☐ PIP (Personal Injury Protection)

PRESCRIPTION

☐ Cyclobenzaprine ☐ 5mg ☐ 10mg	SIG: 1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Amitriptyline ☐ 25mg ☐ 50mg	SIG: 1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Ibuprofen ☐ 800mg ☐ 600mg	SIG: 1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Naproxen ☐ 375mg ☐ 500mg	SIG: 1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Gabapentin ☐ 300mg ☐ 400mg ☐ 600mg	SIG: 1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Tizanidine ☐ 2mg ☐ 4mg	SIG: 1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Methocarbamol ☐ 500mg ☐ 750mg	SIG: 1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Diclofenac Sodium ☐ 75mg ☐ 50mg	SIG: 1	2	3	TAB	PO	QD	BID	TID	QTY:_____ Refills_____
☐ Omeprazole ☐ 20mg ☐ 40mg	SIG: 1	2	3	TAB	PO	QD	BID		QTY:_____ Refills_____
☐ Ranitidine ☐ 150mg ☐ 300mg	SIG: 1	2	3	TAB	PO	QD	BID		QTY:_____ Refills_____
☐ Meloxicam ☐ 7.5mg ☐ 15mg	SIG: 1	2	3	TAB	PO	QD	BID		QTY:_____ Refills_____
☐ Citalopram ☐ 20mg ☐ 40mg	SIG: 1	2	3	TAB	PO	QD			QTY:_____ Refills_____
☐ Medrol Dose Pack	SIG: Use As Directed on package								
☐ Prednisone 10mg	SIG:_____								QTY:_____ Refills_____
☐ Capsaicin 0.025% 60gm	SIG:_____								QTY:_____ Refills_____
☐ Salonpas Patch	SIG:_____								QTY:_____ Refills_____

ALL controlled substance quantities must be hand written in number and letter form

Prescriber's Name:_____ Office Contact:_____
Street Address:_____ Suite #:_____
City:_____ State:_____ Zip:_____ Tel:_____
License #:_____ NPI #:_____ DPS #:_____ DEA #:_____

Prescriber's Signature (signature required. NO STAMPS) _____ Date:_____

IMPORTANCE NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Medicare and Medicaid or another state funded program will not cover above mentioned compounds. Co-payments due at dispensing of the medication

Please fax completed form to 1 855-595-2955