

## **MYCELIUM PHARMACY**

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Patient Name:	Phone #:		DOB:
Address:	City:		State: Zip:
Allergies:			·
Prescriber Name:	NPI:		DEA:
Address:	City:		State: Zip:
Phone #: Fax #	Fax #: Date:		
PGE-1 Injection ☐ 5ml or ☐10ml	TriMix Injection ☐ 5ml or ☐	]10ml	QuadMix Injection ☐ 5ml or ☐10ml
<ul><li>□ 10 mcg/ml</li><li>□ 20 mcg/ml</li></ul>	0, 1, 1		Phentolamine mg/Papavaerine mg/ PGE mcg/ Atropine mg
<ul><li>□ 40 mcg/ml</li><li>□ Other mcg/ml</li></ul>	☐TriMix Single 1/30/10/ml		□QuadMix 1/30/10/0.15/ml
Bi-Mix Injection ☐ 5ml or ☐ 10ml	☐TriMix Double 2/60/20/ml ☐TriMix (Red) 0.5/27/10/ml		□QuadMix 2/30/20/0.15/ml
Phentolamine mg/Papavaerine mg			□QuadMix 2/30/60/0.15/ml
☐Bi-Mix 0.5/30/ml	☐TriMix (Silver) 1/27/10/ml		□QuadMix/ml
☐ Bi-Mix 1/30/ml	□TriMix (#2) 0.5/30/20/ml □TriMix (#3) 1/12/10/ml □TriMix (#4) 2/30/20/ml □TriMix (Other)/ml  SIG: Inject 0.1 ml intracavernosally to start  Alternate SIG: Inject  Number of Refills:		☐ SIG: Inject 0.1 ml intracavernosally to start  Alternate SIG: Inject
☐ Bi-Mix 2/30/ml			
☐ Bi-Mix 3/30/ml			
☐ Bi-Mix Other//ml			Number of Refills:
☐ SIG: Inject 0.1 ml intracavernosally to start			□Phenylephrine Kit 1mg/ml #5
Alternate SIG: Inject			SIG: Inject 0.25ml intracavernosally every 15 minutes as needed for prolonged erections. If not resolved after 60 minutes, go to ER.
Number of Refills:			
☐ Testosterone Cypionate 200mg/ml Qty: 10ml Number of Refills:		□Syringe	escc/mlGin/mm Qty:
SIG: Inject ml intramuscularly times weekly.		SIG: Use as directed for injection. Refills:	
Prescriber's Signature:			
Date:			

This is a custom compounded prescription and may be filled at any pharmacy of the patient's choosing

- Neither the prescriber nor the practice profit from this transaction in any way.

<sup>\*\*</sup>A note to patients from the physician. \*\*