marchese PHARMACY

TRIMIX ORDER FORM

Fax to: 844-444-0528

Phone: 800-356-3365 x120

Prescriber Clinic Information

Practice Name:		
Street Address:		
City:	Province:	Postal Code:

Patient Information

Full Name:		DOB:
Street Address:		
City:	Province:	Postal Code:
Phone:	Email:	
Allergies:	Sex:	Health Card:

Rx: compounded sterile injection

Please select the appropriate concentration, or request a unique formulation:

	ALPROSTADIL 10MCG/ML PAPAVERINE 30MG/ML PHENTOLAMINE 1MG/ML (REGULAR TRIMIX) 3mL vial
	ALPROSTADIL 25MCG/ML PAPAVERINE 30MG/ML PHENTOLAMINE 2MG/ML (TRIMIX HIGH POTENCY) 3mL vial
	ALPROSTADIL 50MCG/ML PAPAVERINE 24MG/ML PHENTOLAMINE 4MG/ML (TRIMIX ULTRA POTENCY) 3mL vial
	ALPROSTADIL 60MCG/ML PAPAVERINE 26MG/ML PHENTOLAMINE 3MG/ML (TRIMIX **MAX** POTENCY) 3mL vial
	ALPROSTADIL 5MCG/ML PAPAVERINE 15MG/ML PHENTOLAMINE 0.5MG/ML (TRIMIX LOW POTENCY) 3mL vial
	Other (Please Specify):

Prescriber Section

Prescriber Name:	Phone #:	License #:
Prescriber Signature:		Date:

Order Quantity (mL): **Number of Refills:**