Dr. Last Name, First Name: _____ Address 1: _____
DEA #: _____ City, State, Zip Code: _____
State License #: _____Tel: _____ Fax: _____

COMPOUNDED LIPOTROPIC PRESCRIPTION ORDER FORM

(PLEASE FILL INFORMATION BELOW)

Patient Name: _____ DOB: _____ Address:_____

Phone: (____) ____-_____ Cell: (____) ____-_____ Allergies: _____ ☐ NKDA

SHIPPING (**CHOOSE 2**): ☐ SHIP TO OFFICE ☐ SHIP TO PATIENT (☐ **FEDEX GROUND** ☐ **2nd Day FEDEX** ☐ **FEDEX Overnight)**

☐ #397 CYANOCOBALAMIN 1MG/ML ☐10ML ☐30ML	☐ ____ # VIAL		
☐ #2160 (Methionine 12.5mg/Inositol 25mg/Choline 25mg/Dexpanthenol 5mg/Pyridoxine 5mg/Cyanocobalamin 1000mcg/Leucine 1.5mg/L-Carnitine 25mg/ml/Lidocaine 1%) Formally #1899 ☐ 30ML	☐ ____ # VIAL		
☐ #361 METHYLCOBALAMIN 1MG/ML ☐30ML	☐ ____ # VIAL		
OTHER:			

Physician Signature: _____ Print Name: _____ Date: _____

Please fax to **303-321-1541** before 3:00PM EST

Or e-mail to sales@apinjections.com