RxCompoundStore.com

FAX PRESCRIPTION: 1-844-875-0009 Tel: 1-844-793-3879

Ship to: [ ] Patient Address [ ] Office Address

Patient Name:_____ Date:_____
Address:_____City:_____
State:_____Zip:_____Phone:_____
Email:_____
D.O.B:_____Allergies:_____

PDE5 Inhibitors

1. TADALAFIL Gummy Troche [ ]6mg [ ]18mg

Qty:[ ]10 [ ]30 [ ]____ Refills: [ ] 11 [ ] ____

Directions: [ ] Take one gummy daily as directed

OR [ ] _____

2. SILDENAFIL Gummy Troche[ ]110mg Tablets[ ] 20mg

Qty:[ ]10 [ ]15 [ ]____ Refills: [ ] 11 [ ] ____

Directions:[ ] Take as directed 30 mins before activity

OR [ ] _____

Physician Name:_____NPI:_____

Physician Phone Number: _____Email:_____

Physician Signature:_____