Anal Fissure Order Form

Please fax orders to:
800.985.4363

Ship to: Patient Bill to: Patient

Please complete the information below. Missing, incomplete, or illegible information will cause a delay in your order.

Patient Information

Name:		Date of Birth:			
Address:					
City:		State:		Zip:	
Phone (H):		Cell / Day Phone:			
E-mail:		Allergies:			

Prescriber Information

Prescriber Name:		Prescriber Signature:			
Practice Name:					
DEA License #:		State License #:			
Address:					
City:		State:		Zip:	
Phone:		Fax:			
E-mail:					

Compound Prescription Information

Preparation	Form	Qty.	Sig	Refills
☐ Diltiazem 2%	Cream	50gm per jar	*Apply 0.5 cc in the anal canal three times daily for four weeks or as directed.*	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ Diltiazem 4%	Cream	50gm per jar	*Apply 0.5 cc in the anal canal three times daily for four weeks or as directed.*	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ Nifedipine 0.2%	Cream	50gm per jar	*Apply 0.5 cc in the anal canal three times daily for four weeks or as directed.*	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ Nifedipine 0.4%	Cream	50gm per jar	*Apply 0.5 cc in the anal canal three times daily for four weeks or as directed.*	☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

DoseRite™ System Information

Item	DoseRite™ Contents
DoseRite™ System	84 applicators, 12 dosing syringes, and a dosing syringe connector for each 4-week regimen

Billing & Shipping Information

Credit Card:	☐ VISA ☐ MC ☐ DISC ☐ AMEX	☐ Bill Card on File ☐ Bill Card listed below	
Name On Card:			
Credit Card #:		Expiration Date:	
Shipping Location:	☐ Ship to Patient ☐ Ship to Prescriber		
Shipping Type:	☐ Fedex 2nd Day (*Free*) ☐ Fedex Standard Overnight (*Call for pricing*)		

By submitting this script, you acknowledge that this compounded preparation is necessary for the patient identified above.