Q2 2026

PharmaLabs

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HOURS:

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Call in: (857) 233-5837 x2
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Prescription Order Form – P: (857) 233-5837 x 2 F: (888) 247-0840

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☐ **Bill to Patient** ☐ **Bill to Practice**

☐ **Ship to Residence** ☐ **Ship to Office**	Shipping Address: _____ _____

Patient Name: _____ Date: _____

Date of Birth: _____ Patient Phone: _____ Email: _____

ERECTILE DYSFUNCTION

Intracavernosal Injection

	Mixture	Papaverine (mg/mL)	Phentolamine (mg/mL)	PGE1 (mcg/mL)	Atropine (mcg/mL)
☐	**PGE1***	–	–	25	–
☐	**Bimix #30/2**	30	2	–	–
☐	**Bimix #3**	15	0.5	–	–
☐	**Bimix #4**	30	1	–	–
☐	**Bimix #10**	30	4	–	–
☐	**Trimix #5**	30	1	10	–
☐	**Trimix #6**	30	4	2.5	–
☐	**Trimix #7**	30	4	5	–
☐	**Trimix #8**	30	2	20	–
☐	**Trimix #9**	30	4	40	–
☐	**Trimix #11**	30	4	7.5	–
☐	**Trimix #12**	30	4	10	–
☐	**Trimix #13**	30	6	60	–
☐	**Trimix #14**	30	1	2.5	–
☐	**Trimix #15**	30	2	40	–
☐	**Trimix #16**	30	6	100	–
☐	**Quadmix 30/2/10/100**	30	2	10	100
☐	**Quadmix 30/3/40/200**	30	3	40	200

SIG: Dispense 1 Month Supply **QTY:** 5mL **Refills:** _____
Inject _____ units intracavernosally as instructed
Increase or decrease by _____ units
Maximum Dose _____ units
May use ☐ Daily ☐ 3-4 times weekly

CHOOSE SYRINGE:
☐ 1cc: 31 gauge x 5/16" insulin syringes **QTY:** 10
☐ 1cc: 29 gauge x 1/2" insulin syringes **QTY:** 10
*PGE1 Only: ☐ By checking this box, prescriber has determined PGE1 compound is medically necessary.

Priaprism Rescue

☐ Phenylephrine 1mg/mL **QTY:** 10mL **Refills:** _____
SIG: Inject _____ units intracavernosally for erections lasting longer than 2.5 hours. Max Dose is ___ units. May repeat in 15 minutes if erection does not subside. May perform a total of 3 doses. Proceed to the emergency room if erection persists.

☐ Pseudoephedrine 30mg tablet **QTY:** 30 Tablets **Refills:** _____
SIG: Take ____ tablet(s) by mouth as needed for an erection lasting longer than 2.5-3 Hours.

Retail, Injection Accessories, & Supplements

☐ Alcohol Prep Pads **QTY:** _____
☐ Autoject EI **QTY:** _____
☐ FirmTech Tech Ring **QTY:** _____
☐ Constriction Loop **QTY:** _____
☐ FirmTech Performance Ring **QTY:** _____
☐ FirmTech Tech Ring **QTY:** _____
☐ MYHIXEL Ring - Light **QTY:** _____
☐ MYHIXEL Ring - Firm **QTY:** _____
☐ MYHIXEL Ring - Intense **QTY:** _____
☐ MYHIXEL Ring - 3 Ring Bundle **QTY:** _____

☐ Insul-Tote **QTY:** _____
☐ Insul-Ease **QTY:** _____
☐ Sharps Container **QTY:** _____
☐ N-Acetyl Cysteine 600mg **QTY:** _____
☐ Trimix Starter **QTY:** _____
☐ ICI Essentials **QTY:** _____
☐ Uberlube **QTY:** _____
☐ Popstar Silicone-based Lube **QTY:** _____
☐ Popstar Water-based Lube **QTY:** _____
☐ Box of 100 - 29G 5/16" 1CC **QTY:** _____
☐ Box of 100 - 31G 1/2" 1CC **QTY:** _____

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ERECTILE DYSFUNCTION

Vacuum Erection Devices & Accessories

☐ Manual Augusta SomaTherapy System **QTY:**_____ ☐ Battery Augusta SomaTherapy System **QTY:** _____	☐ Owen Mumford Manual Vacuum Erection Device **QTY:** _____

Intraurethral Gel

	Mixture	Phentolamine (mg/mL)	PGE1 (ug/mL)
☐	**GEL**	4	1000
☐	**GEL**	10	–
☐	**GEL**	20	–

QTY: 15mL **Refills:** _____
SIG: Insert _____ mL intraurethrally. Increase or decrease by _____ mL until desired effect is achieved. Maximum dose _____ mL. May use 1x Daily.

PDE5 Inhibitors

☐ Sildenafil 20mg Tablet **SIG:** Take 20-100mg by mouth as needed, not more than once daily. **QTY:** 90 tab **Refills:** _____
☐ Sildenafil 100mg Tablet **SIG:** Take 100mg by mouth as needed, not more than once daily. **QTY:** 90 tab **Refills:** _____
☐ Vardenafil 12mg Lozenge **SIG:** Dissolve 1 by mouth as needed, not more than once daily. **QTY:** 10 Lozenge **Refills:** _____
Tadalafil Lozenge ☐ 5mg/ ☐ 20mg **SIG:** Dissolve 1 by mouth as needed, not more than once daily. **QTY:** 30 Lozenge **Refills:** _____
Tadalafil Tablet ☐ 5mg/ ☐ 10mg/ ☐ 20mg **SIG:** Take 1 by mouth as needed, not more than once daily. **QTY:** 30 tab **Refills:** _____
Custom SIG: _____

HAIR, HEALTH, AND WELLNESS

☐ Finasteride Tablets – 1mg **SIG:** Take 1 by mouth daily. **QTY:** 30 Tablets **Refills:** _____
☐ Finasteride + Minoxidil Topical Foam 0.1%/ 6% 90mL **SIG:** Apply daily as directed. **Refills:** _____
Valacyclovir ☐ 500mg / ☐ 1,000mg Tablet Take _____ tablet(s) _____ every _____ **QTY:** 30 Tablets **Refills:** _____
SIG: _____

PEYRONIE'S DISEASE

Verapamil	Pentoxifylline
☐ Verapamil Cream 12% Dispensed in a 30mL Pump Jar **SIG:** Apply 0.5mL (1 Pump) 2x per day for 30 days. **QTY:** (# of 30mL Jars) _____ **Refills:** _____	☐ Pentoxifylline 400mg tablet **SIG:** Take 2 to 3 tablets per day as direct **QTY:** (# of Tablets) _____ **Refills:** _____
	☐ Understanding Peyronie's Disease – Book by Dr. Laurence Levine **QTY:** _____

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HORMONE REPLACEMENT

Anastrozole

☐ Anastrozole Tablets ☐ 1mg **QTY:** 30 Tablets **Refills:** _____
SIG: Take ____ tablet(s) by mouth once weekly; or _____

Clomid: Clomiphene Citrate

☐ Clomiphene Citrate 25mg Capsules **SIG:** Take _____ capsule by mouth ____ daily/ weekly (circle one) ☐ Clomiphene Citrate 50mg Capsules **SIG:** Take _____ capsule by mouth ____ daily/ weekly (circle one)	**QTY:** _____ or circle one: **Refills:** _____	15 capsules 30 capsules 45 capsules	60 capsules 90 Capsules

Enclomiphene

☐ Enclomiphene 12.5mg Capsules **SIG:** Take _____ capsule by mouth ____ daily/ weekly (circle one) ☐ Enclomiphene 25mg Capsules **SIG:** Take _____ capsule by mouth ____ daily/ weekly (circle one)	**QTY:** _____ or circle one: **Refills:** _____	15 capsules 30 capsules 45 capsules	60 capsules 90 Capsules

Testosterone Supplement

☐ Drive Testosterone Support 1 Bottle (30 Capsules)

Tesosterone Gel

☐ 50mg/mL (5%) Apply _____ mLs every _____ **QTY** (Total mLs): (numerical and written) _____ mLs **Refills:** _____
Apply ____ mls (# of clicks) Topically to clean, dry skin ____ (daily, twice daily)
☐ 200mg/mL (20%) Apply _____ mLs every _____ **QTY** (Total mLs): (numerical and written) _____ mLs **Refills:** _____
Apply ____ mls (# of clicks) Topically to clean, dry skin ____ (daily, twice daily)

Kyzatrex (Testosterone Undecanoate)

☐ Kyzatrex (Testosterone Undecanoate) 200mg Capsules **SIG:** Take 2 Capsules/ Twice a Day	**QTY:** _____ (120 Capsules Per Bottl) or circle one: **Refills:** _____	120 capsules 240 capsules 360 capsules

Testosterone Nasal Spray

☐ Testosterone Nasal Spray 5.5mg **QTY**: _____ 12mL Bottle(s) **Refills:** _____ **SIG:** 1-2 sprays per nostril not more than once daily.

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HORMONE REPLACEMENT

DHEA (Dehydroepiandrosterone)

☐ DHEA (Dehydroepiandrosterone) 100mg Capsules **QTY:**____ Capsules **Refills:** _____ **SIG:** Take 1 capsule daily

Progesterone

☐ Progesterone 100mg Capsules **QTY:**____ Capsules **Refills:** _____ **SIG:** Take 1 capsule by mouth at bedtime

Generic Pregnyl (HCG)

☐ 1,000iu/mL **QTY** (1) 10mL vial **Refills:** _____ **SIG:** Inject _____ mLs (Circle SC or IM) _____ (Add Frequency)

CHOOSE SYRINGE:

☐ 1cc: 31 gauge x 5/16" insulin syringes **QTY:** (10 Per Bag) ____ Bags

☐ 1cc: 29 gauge x 1/2" insulin syringes **QTY:** (10 Per Bag) _____ Bags

Estradiol Pellets

☐ Estradiol Pellets 10mg **QTY**: (numerical and written) _____ **Refills:** _____

SIG: _____

☐ Trocar Kit: 3.5mm Stainless Disposable **QTY**: _____

Testosterone Pellets

☐ Testosterone Pellets 87.5mg **QTY**: _____ **SIG:** _____

☐ Trocar Kit: 3.5mm Stainless Disposable **QTY**: _____ **SIG:** _____

☐ Testosterone Pellets 100mg **QTY**: _____ **SIG:** _____

☐ Trocar Kit: 3.5mm Stainless Disposable **QTY**: _____ **SIG:** _____

☐ Testosterone Pellets 200mg **QTY**: _____ **SIG:** _____

☐ Trocar Kit: 4.5mm Stainless Disposable **QTY**: _____ **SIG:** _____

DEPO Testosterone Cypionate 200mg/mL

☐ DEPO Testosterone Cypionate 200mg **QTY** (1) 10mL (TEN) vial **Refills:** ____

SIG: Inject ___ mLs intramuscularly ___ weekly, twice weekly, biweekly (circle one) *Please discard 28 days after first puncture*

☐ Needles: 18G draw + 23G x 1" for IM injection. QTY: 10

CHOOSE INTRAMUSCULAR SYRINGE:

☐ 21G Intramuscular Needle and 1" Syringe **QTY:** 10
☐ 22G Intramuscular Needle and 1" Syringe **QTY:** 10
☐ 23G Intramuscular Needle and 1" Syringe **QTY:** 10
☐ 25G Intramuscular Needle and 1" Syringe **QTY:** 10
☐ 27G Intramuscular Needle and 0.5" Syringe **QTY:** 10

CHOOSE INTRAMUSCULAR SYRINGE:

☐ 21G Intramuscular Needle and 1.5" Syringe **QTY:** 10
☐ 22G Intramuscular Needle and 1.5" Syringe **QTY:** 10
☐ 23G Intramuscular Needle and 1.5" Syringe **QTY:** 10
☐ 25G Intramuscular Needle and 1.5" Syringe **QTY:** 10
☐ 27G Intramuscular Needle and 1.25" Syringe **QTY:** 10

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PELVIC HEALTH

Overactive Bladder

☐ Mirabegron 20mg Capsules **QTY:** 30 Capsules **Refills:** _____ **SIG:** Take 1 Capsule/ Day ☐ Mirabegron 40mg Capsules **QTY:** 30 Capsules **Refills:** _____ **SIG:** Take 1 Capsule/ Day	☐ ProtechDry Underwear **QTY:** _____ ☐ Lunderg Confidence Clamp **QTY:** ___ ☐ Minze Diary Pod + App **QTY:** _____

BPH

☐ Finasteride 5mg Tablets: Take 1 Tablet/ Day **QTY:** 90 Tablets **Refills:** _____
☐ Tamsulosin 0.4mg Capsules: Take 1 Capsule/ Day **QTY:** 90 Capsules **Refills:** _____
☐ Flosom + CBD Dietary Supplement 1 bottle (30 capsules)

Bladder Irrigation

☐ Mitomycin Solution 40mg Solution (5mg/mL) Dispense 8mL Vial **SIG:** Dilute 8 mLs mitomycin solution with sterile water to produce final concentration **QTY:** (# of 8mL Vials) _____ **Refills:** _____	☐ DMSO/ Lidocaine 50%/ .5% (W/V) in 50mL **SIG:** Instill into bladder as directed **QTY:** (# of 50mL Vials) _____ **Refills:** _____

☐ Mitomycin Sterile Water Kit: **SIG:** Use as directed for dilution of Mitomycin
Kit includes: Chemo-Rated Gloves, Syringe, 18G Needle, Bag and 50mL Sterile Water for injection
***QTY of Kits will match the number of vials of Mitomycin ordered**

TOPICAL CREAM

BLT Cream – Jar

☐ Extra Strength (20% Benzocaine/ 6% Lidocaine/ 4% Tetracaine)
QTY: ☐ 30g ☐ 60g **Refills:** _____ **SIG:** ☐ Use as directed ☐ **Custom Sig:** _____

SKIN HEALTH

Estriol 0.3%/Sodium Hyaluronate 0.5% Cream

☐ Estriol 0.3%/Sodium Hyaluronate 0.5% Cream
QTY: ☐ 30mL Pump **Refills:** _____ **SIG:** Apply 1 Pump (0.5mL) Daily to affected areas on face.

WOMEN'S HEALTH

Vaginal Cream – Estradiol – 0.125mg/mL (0.0125%)

☐ Insert 1mL (4 clicks) via applicator vaginally twice a week.
QTY: (total mLs) _____ or circle one: 15mL 30mL 45mL 60mL 90mL **Refills:** _____

Vaginal Cream – Estradiol/DHEA – 125mg/10mg/mL (0.0125% / 1%)

☐ Insert _____ clicks (1 click = 0.25mL = 0.25g) every _____
QTY: (total mLs) _____ or circle one: 15mL 30mL 45mL 60mL 90mL **Refills:** _____

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WOMEN'S HEALTH

Vaginal Cream – Testosterone/DHEA/Estradiol – 1mg/3mg/0.5mg/mL

Vaginal Cream – Testosterone/DHEA/Estradiol – 1mg/3mg/0.5mg/mL
☐ Apply _____ clicks (1 click = 0.25mL = 0.25g) every _____
QTY: (total mLs) _____ or circle one: 15mL 30mL 45mL 60mL 90mL **Refills:** _____

Topical Cream – Testosterone 10mg/mL

☐ ___ mL **QTY:** _____ **Refills:** _____ or Circle One: **SIG:** Apply ___ clicks per day for 90 days	☐ 22.5mL **QTY:** ___ **Refills:** ___ **SIG:** Apply 1 click per day for 90 days ☐ 45mL **QTY:** ___ **Refills:** ___ **SIG:** Apply 2 click per day for 90 days ☐ 67.5mL **QTY:** ___ **Refills:** ___ **SIG:** Apply 3 click per day for 90 days ☐ 90mL **QTY:** ___ **Refills:** ___ **SIG:** Apply 4 click per day for 90 days

Topical Cream – Estradiol/ Testosterone 1mg/10mg/mL

☐ ___ mL **QTY:** _____ **Refills:** _____ or Circle One: **SIG:** Apply ___ clicks per day for 90 days	☐ 22.5mL **QTY:** ___ **Refills:** ___ **SIG:** Apply 1 click per day for 90 days ☐ 45mL **QTY:** ___ **Refills:** ___ **SIG:** Apply 2 click per day for 90 days ☐ 67.5mL **QTY:** ___ **Refills:** ___ **SIG:** Apply 3 click per day for 90 days ☐ 90mL **QTY:** ___ **Refills:** ___ **SIG:** Apply 4 click per day for 90 days

REQUIRED FOR TESTOSTERONE PRESCRIPTIONS
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WELLNESS/LONGEVITY

Low Dose Naltrexone

☐ Low Dose Naltrexone 1.5mg Capsules **SIG:** Take _____ capsule(s) by mouth daily ☐ Low Dose Naltrexone 4.5mg Capsules **SIG:** Take _____ capsule(s) by mouth daily	**QTY:** _____ or circle one: 15 Capsules 30 Capsules 60 Capsules 90 Capsules **Refills:** _____

PT-141 Bremelanotide

☐ Bremelanotide 1mg Lozenges **QTY:** _____ **Refills:** _____
SIG: Dissolve _____ lozenge(s) in mouth _____ times per day
☐ Bremelanotide 2mg Lozenges **QTY:** _____ **Refills:** _____
SIG: Dissolve _____ lozenge(s) in mouth _____ times per day

Ondansetron ODT

☐ Ondansetron ODT 4mg Tablets **QTY:** _____ **Refills:** _____
SIG: Dissolve ____ tablet(s) in mouth ____ daily/ weekly (circle one)

Phentermine

☐ Phentermine 37.5mg **QTY:** _____ Tablets **Refills:** _____ **SIG:** Take 1 tablet by mouth every morning

Metformin

☐ Metformin 500mg **QTY:** _____ Tablets **Refills:** _____ **SIG:** Take once or twice a day with food

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WELLNESS/LONGEVITY

Subcutaneous Injections

☐ Sermorelin Injection 1.5mg/mL – 10mL Vial **QTY:** _____ Vials **Refills:** _____
SIG: Inject _____ Units every night at bedtime 5 days a week on an empty stomach.

☐ BPC-157 Kit – Kit Includes: 10mg (undiluted) 5mL Vial + 23G Draw Syringe + 5mL barrel + Bac Water
QTY: _____ Kits **Refills:** _____ **SIG:** Inject ____ mcg subcutaneously/ intramuscularly (circle one) near affected area daily.

☐ NAD+ 100mg/mL – 10mL Vial **QTY:** _____ Vials **Refills:** _____
SIG: Inject ___ Units subcutaneously Monday, Wednesday, and Friday.

☐ NAD+ Testing Kit **QTY:** _____

☐ Glutathione 200mg/ml – 30mL Vial **QTY:** _____ Vials **Refills:** _____
SIG: Inject 1-2mL's 1-2 times weekly

CHOOSE SUBCUTANEOUS SYRINGE:	**CHOOSE INTRAMUSCULAR SYRINGE:**
☐ 1cc: 31 gauge x 5/16" insulin syringes **QTY:** 10	☐ 21G Intramuscular Needle and 1" Syringe **QTY:** 10
☐ 1cc: 29 gauge x 1/2" insulin syringes **QTY:** 10	☐ 23G Intramuscular Needle and 1" Syringe **QTY:** 10
☐ 3cc: 30 gauge x 1/2" insulin syringes **QTY:** 10	☐ 25G Intramuscular Needle and 1" Syringe **QTY:** 10
	☐ 27G Intramuscular Needle and 0.5" Syringe **QTY:** 10

WELLNESS/ LONGEVITY SUPPLEMENTS

☐ Metabolic Essentials – 1 Bottle (60 Capsules) **QTY:** _____ **Refills:** _____

☐ Cardio Health Essentials – 1 Bottle (90 Capsules) **QTY:** _____ **Refills:** _____

☐ Collagen Essentials – 8oz Bottle (30 Servings) **QTY:** _____ **Refills:** _____

☐ Probiotic Essentials – 1 Bottle (30 Capsules) **QTY:** _____ **Refills:** _____

☐ Calocurb – 1 Bottle (90 Capsules) **QTY:** _____ **Refills:** _____

SEMEN HEALTH

Popstar Supplements

☐ Fertility – 1 Bottle (90 Capsules) **QTY:** _____
☐ Volume + Taste – 1 Bottle (120 Capsules) **QTY:** _____

CLIMAX CONTROL/ DELAYED EJACULATION

☐ MyHixel Control Device + Play App **QTY:** _____	☐ Promescent Endurance Spray – 60 **QTY:** _____
☐ MyHixel Hands-Free Accessory **QTY:** _____	☐ Promescent Endurance Spray – 20 **QTY:** _____
☐ MyHixel Replacement Sleeve **QTY:** _____	☐ Popstar Delay Spray – 75 **QTY:** ____

☐ Oxytocin 200iu Rapid Dissolve Tablets **QTY:** _____ **Refills:** ____
Dissolve ____ lozenge(s) in mouth ____ (as needed, once daily, 15-30 minutes prior to sexual activity)

Scream Cream (Libido Cream) – Sildenafil/ Theophylline/ Arginine (2%/ 2.5% 6%)

☐ Scream Cream 20mL **QTY:** (circle one) 1 Jar (20mL) 2 Jars (40mL) **Refills:** _____
Apply ____ pump (0.5mL) to the vaginal area 15-30 minutes prior to sexual activity.

Provider Name (Printed):	Provider Address:	Provider Signature: