HAIR LOSS

Prescriber:		Patient:	D.O.B.:
Address:		Mobile Phone:	Home Phone:
City:	State: Zip:	Address:	
Phone:	Fax:	City:	State: Zip:
NPI:	DEA:	Allergies:	

		Take one by mouth:	Choose Qty:
☐ **Dutasteride / Anastrozole Capsules**	0.8 / 0.15mg	☐ QDAY	☐ 30
☐ **Finasteride/Minoxidil Capsules**	1/2.5mg ☐	Other	☐ 90
	1/5mg ☐	_____	Refills:_____

		SIG: Apply ____ pumps:	Pump Qty:
☐ **Dutasteride / Biotin** (50mL Pump Bottle)	0.1% /0.2%	☐ BID	☐ 1
☐ **Minoxidil / Finasteride Solution** (50mL Pump Bottle)	5% / 0.1%	☐ QDAY	☐ 2
			☐ 3
		Other:_____	Refills:_____

	Apply 20-30 drops	
☐ **82F** Minoxidil (5%) + Tretinoin (0.01% + Fluocinolone Acetonide (0.01%) + Finasteride (0.25%)	SIG:	Dispense Qty:
☐ **82D** Minoxidil (5%) + Tretinoin (0.01% + Fluocinolone Acetonide (0.01%) + Dutasteride (0.75%)	☐ BID	☐ 120mL
☐ **82M** Minoxidil (5%) + Tretinoin (0.01% + Fluocinolone Acetonide (0.01%)	☐ QDAY	☐ 180mL
	Other:_____	Refills:_____

PRESCRIBER:

Signature:_____ Date: ☐☐ ☐☐ ☐☐☐☐

Fax to the Pharmacy at 888-560-6691 or 940-382-2694.