

2381 Frederick Douglass Blvd New York. NY 10027 (P) (212)749-6626 (F) (212)749-6629 35 Valley Ave Elmsford, NY 10523 (P) (914 840 - 5027 (F) (914) 840 - 5022 85 Outwater Lane Unit 7 Garfield, NJ 07026 (P) (862) 225 - 9422 (F) (862) 225 - 9423

#### Dationt Information

Prescriber Signature: \_

Email: info@ahmarx.com

1 diloni	mormation										
Patient N	Name:	Ι	Date o	f Birth:			] Ma	ıle 🗆	Fema	ale	
Address				City: State:						Zip:	
Phone: Alt Pho							Pre	ferred La	ngua	ge:	
Allergies	s (Required):			□ NKI	DA	Height:	-		Wei	ght:	
Product	Shipping Options: Patient's Home	Provider's	Offic	e	ddress	3:					
Prescrib	er Information										
Practice	Name:				Office	Contact	i:				
Prescribe	er:		NPI:	•			D	EA:			
Address:	ddress: City:					s	tate:	Zip:			
Phone:	Fax:							l			
Prescrip	otion Information										
	Medication				Direc	tions		Patie	nt Co	st	Refills
odiatry	☐ Salicylic Acid 20%/Fluorouracil 4% DMSO	) Wart Rem	over	Apply 1	to affec	ted nail(s	) QD	\$35 fo	or 10n	ml	
	☐ Fluconazole 2%/Ibuprofen 2% Hydrogel			Apply t	Apply to affected nail(s) QD				\$35 for 8ml		
	☐ Clotrimazole 2%/Ibuprofen 2% DMSO Nai	I Solution		Apply t	to affec	ted nail(s	) QD	) QD \$35 for 8m			
culation	☐ Pentoxifylline 5%/ Nifedipine 2%/Lidocaine	e 6% Lipod	erm		ected area(s)  D   TID   QID   \$50		\$50 1	for 30	g		
Other	☐ Minoxidil 10% Topical Solution			Apply t	to affec	ted nail(s	) QD	\$35 fo	or 10n	nl	
Prescrib	er Signature (Please sign and date be	elow)									

Date



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1 at	CII	t illiorillation											
Pati	ent	Name:	ı	Date	of Birth:			☐ Ma	ale	□Fen	nale		
Address:					City:				Sta	te:	Zip:		
Phone: Alt Phone				e:	П			Pre	eferre	d Langu	age:		
Alle	rgie	es (Required):			□NK	DA	Height	t:		W	eight:		
Pro	duc	t Shipping Options: Patient's Home I	Provider's	o Offic	ce	.ddress	s:			•			
Pres	scri	iber Information											
Pra	ctic	e Name:				Office	Contac	ct:					
Pres	scri	ber:		NP	l:				DEA:				
Add	res	s:		City	<i>/</i> :			S	State:		Zip:		
Pho	ne:			Fax	α:								
Pres	scri	iption Information											
		Medication				Direc	tions			Pati	ent Cost	Ref	ills
ir Los	S	☐ <b>Hair Serum F</b> Minoxidil 5%/ Finasteride 0.1%/Tretinoin 0.01%/Fluocinolone 0.01% Topical Solution				Apply to □ QD				\$60	for 60ml		
		☐ Hair Serum D  Minoxidil 5%/Dutasteride 0.75%/Tretinoin 0.01%/Fluocinolone 0.01% Topical Solution				Apply to				\$80	for 60ml		
		☐ Progesterone 0.5% Shampoo			Massag th		scalp ar es week		e	\$80 ·	for 100ml		
		☐ Minoxidil 2.5mg/Dutasteride 0.5mg Capsule	s		Take c	one caps once	sule by daily	mouth		\$55 for	30 capsules		
Pres	scri	ber Signature (Please sign and date be	low)								VIV.		
Pres	crib	er Signature:				Date	e		Urac	THE REAL PROPERTY.	ACHC STREET	OUALITY PRO	



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	Patient Nan	Date	ate of Birth:				☐ Male ☐			] Female				
	Address:				City:				State:			Zip:		
	Phone:	ne:	и			Р	referre	ed Lar	Language:					
	Allergies (R	equired):			□ NKI	DA	Heigh	nt:			Wei	ght:		
	Product Shi	pping Options: Patient's Home	Provider'	's Offic	ce	ddress	S:							
	Prescriber	Information												
	Practice Na	me:				Office	Conta	act:						
	Prescriber:			NP	l:				DEA:					
	Address:			City	<b>/</b> :				State:	1		Zip:		
	Phone:	Phone:			<b>(</b> :									•
	Prescriptio	n Information												
		Medication				Dire	ctions				Pati	ent Cost	Ref	fills
	/omen's Health	☐ Sildenafil 1% Cream ☐ Sildenafil 3.6% ☐ Sildenafil 2% Cream ☐ Sildenafil 4%			Apply	a pea- QD	sized a PRN	amour	nt		\$65	5 for 30g		
		☐ Testosterone 0.8% Cream		,	Apply 2 clic	ks (4m	g) topic	cally C	D PRN	٧		75 for 30g 95 for 60g		
		☐ Estradiol 0.01% Ointment			Apply a p		d amoi		vulva		\$45	5 for 30g		
g	Skin mentation	☐ Hydroquinone 4%/Tretinoin 0.1%/ Azela 15%/Hydrocortisone 1% Cream	aic Acid		Apply NOTE: MU	to affec					\$65	5 for 30g		
	Prescriber	Signature (Please sign and date be	low)											
	Prescriber S	ignature:							urac	C°)	GILLE A.C.	CHC MILITARY	A COMMISSION	**



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Prescriber Signature: \_

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rallelli	t illioilliation									
Patient	Name:		Date of Birth:			Male	□Fer	male		
Address	s:	City: S				ate:	Zip:			
Phone:		ne:		ı	Preferre	ed Langu	ıage:			
Allergie	es (Required):		□NK	DA	Height:		w	eight:		
Product	t Shipping Options:	Provider's	's Office ☐ Alt A	ddress:			'			
Prescri	ber Information	N.								
Practice	e Name:			Office (	Contact:					
Prescrib	ber:		NPI:			DEA:				
Address:			City:			State	•	Zip:		
Phone:			Fax:							
Prescri	ption Information									
1 100011										
1 103011	Medication		Di	irections			Pat	ent Cost	Refil	lls
					area(s)		□ \$	30 for 30g	Refil	lls
Anal ssures	Medication  Benzocaine 20%/Lidocaine 10%/ Tetracaine 10%		Apply to a	affected a			□ \$ □ \$		Refil	lls
Anal	Medication  Benzocaine 20%/Lidocaine 10%/ Tetracaine 10% Please Select: □ Ointment □ Cream Benzocaine 20%/Lidocaine 6%/ Tetracaine 4%		Apply to a	affected a	D □ QID  area(s)		\$   \$   \$	30 for 30g 60 for 60g	Refil	lls
Anal	Medication  Benzocaine 20%/Lidocaine 10%/ Tetracaine 10% Please Select: □ Ointment □ Cream Benzocaine 20%/Lidocaine 6%/ Tetracaine 4% Please Select: □ Ointment □ Cream		Apply to a □ QD □ B Apply to a	affected a	D □ QID  area(s) D □ QID  area(s)		\$   \$   \$   \$   \$	30 for 30g 60 for 60g 90 for 90g 30 for 30g 60 for 60g	Refil	IIs
Anal	Medication  Benzocaine 20%/Lidocaine 10%/ Tetracaine 10% Please Select: □ Ointment □ Cream Benzocaine 20%/Lidocaine 6%/ Tetracaine 4% Please Select: □ Ointment □ Cream  □ Nifedipine 0.2% Ointment □ Nifedipine 0.3%/Lidocaine 5% Ointment		Apply to a  QD B  Apply to a	affected a affected a ID  TIE	D □ QID  area(s) D □ QID  area(s) D □ QID  area(s)		\$   \$   \$   \$   \$   \$   \$   \$   \$   \$	30 for 30g 50 for 60g 90 for 90g 30 for 30g 60 for 60g 90 for 90g 50 for 30g 60 for 60g	Refil	IIs
Anal ssures	Benzocaine 20%/Lidocaine 10%/ Tetracaine 10% Please Select:	v)	Apply to a  Apply to a  Apply to a  Apply to a  QD B  Apply to a	affected a affected a ID  TIE	D □ QID  area(s) D □ QID  area(s) D □ QID  area(s)		\$   \$   \$   \$   \$   \$   \$   \$	30 for 30g 60 for 60g 90 for 90g 30 for 30g 60 for 60g 90 for 90g 50 for 60g 70 for 90g 64 for 30g 74 for 60g		

Date



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ratienti	nformation											
Patient Na	Date of Birth:				] Mal	e 🔲	Fema	ale				
Address:				City:				State:			Zip:	
Phone: Alt Phone							Pref	erred La	ngua	ge:		
Allergies (Required):				□NK	DA	Height			Wei	ght:		
Product S	Shipping Options:	Provider's	offic	ce □ Alt A	.ddress	s:						
Prescribe	er Information											
Practice N	Name:				Office	Contac	t:					
Prescribe	r:		NPI	:			DE	ĒA:				
Address:			City	:			St	State:			Zip:	
Phone:				Fax:								
Prescript	ion Information											
	Medication			Direction	ıs			Patient C	Cost		Refill	s
al Fissures ontinued)	☐ Nitroglycerin 0.125% Ointment		Apply to affected area(s)  ☐ QD ☐ BID ☐ TID ☐ QID					□ \$30 fo □ \$60 fo □ \$90 fo				
Wounds	☐ Nifedipine 2%/Benzocaine 20%/Lidocaine 8%/Tetracaine 4% Ointment	Apply to affected area(s) nt □ QD □ BID □ TID □ QID				□ \$35 fo □ \$65 fo □ \$95 fo	r 60g					
Pain	☐ Ketoprofen 10%/Gabapentin 5%/Lidocaine 5%/Baclofen 2% Lipoderm	* * * * * * * * * * * * * * * * * * * *					☐ \$70 fo ☐ \$80 fo ☐ \$90 fo	r 60g				
Prescribe	er Signature (Please sign and date be	low)		\ \								
								À	a A	CCREA	OINT COMMI	la-

Date



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Patient Infor	rmation							
Patient Name	:		Date of Birth:		Male	е		
Address:	City:		<b>,</b>	State:	2	Zip:		
Phone:	e:			Preferred La	nguag	e:		
Allergies (Red	quired):		□NK	DA	Height:		Weig	ıht:
Product Shipp	oing Options: ☐Patient's Home ☐	Provider's	s Office ☐ Alt A	ddress:				
Prescriber In	nformation							
Practice Name	e:			Office (	Contact:			
Prescriber:			NPI:			DEA:		
Address:	Address:					State:	Ž	Zip:
Phone:	one: Fax:							
Prescription	Information							
	Medication		Direction	ıs		Quant	ity	Refills
CUSTOM PRESCRIPTION								
Prescriber Si	ignature (Please sign and date be	elow)				-		not come.
Prescriber Sign	nature:			Date		urac	TO ACH	HC AND