Topical Eflornithine Quick Order Sheet

Patient Full Name: _____Patient DOB: _____

Patient Phone #:_____ Patient Address: _____

City: _____ State: _____

·☐ Eflornithine 13.9% Cream; sig: Apply topically to the affected areas twice daily.

·☐ (Custom Rx/Strength/Sig):_____
_

Quantity (grams) #: 30 45 60

Refills: 1 2 3 4 5 6 PRN NONE (CIRCLE AUTHORIZED REFILLS)

Physician Name: _____ NPI or DEA: _____

Office Address:_____ Office Phone Number: _____

Signature: _____

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