PATIENT INFORMATION

"Valid if transmitted by facsimile machine only"

*PATIENT NAME: *DATE OF BIRTH:

☐ Deliver to patient (Free) SSN:

ADDRESS: *PHONE:

CITY: STATE: ZIP: ICD9 CODES/DX:

Insurance ID: Group: BIN: PCN:

Allergies:

MOST REQUESTED FORMULAS

☐ LDN Starter Kit=(Naltrexone 1.5mg Capsule #40 & Naltrexone 0.5mg Capsule #32)
SIG: Take capsules daily prior to bedtime as per starter kit directions

☐ Naltrexone (LDN) 0.5 mg Capsule Quantity: 70 (1st month supply)

SIG: Start at 1 capsule (0.5 mg) at bedtime and titrate up each week by 1 capsule (0.5 mg) to desired effect or physician specified dose

☐ Naltrexone (LDN) ☐ 1.5mg ☐ 3mg ☐ 4.5mg ☐ ____ mg

☐ Naltrexone 3% Transdermal Cream Quantity: 30 grams

SIG: Apply (1-4) clicks 3 to 4 times a day to painful areas

DAYS	LDN 1.5MG	LDN 0.5MG	DOSE PER DAY
1-8	1 CAPSULE DAILY	NONE	1.5MG
9-16	1 CAPSULE DAILY	1 CAPSULE DAILY	2MG
17-24	1 CAPSULE DAILY	2 CAPSULES DAILY	2.5MG
25-32	2 CAPSULES DAILY	1 CAPSULE DAILY	3.5MG
Maintenance Dose	☐ 4.5MG	☐ 5MG	☐ _____MG

Quantity: ____ 30 Day Supply Other Quantity: ____

Sig: _____

Other Requested Formulations: _____

PRESCRIBER

Name: TEL:

SIGNATURE: _____ _____DATE___/___/_____

Dispense as Written May Substituted

FAX (317) 449-0304