DATE _____

ENOVEX
Total Wellness Pharmacy

FEMALE BHRT
Rx Order Form

1111 North Brand Blvd, Unit M Glendale CA 91202
Phone: 818 696 2501 | Fax: 888 333 7911 | info@EnovexRx.com

PATIENT

NAME _____ DOB _____ PHONE _____

STREET _____ CITY _____ STATE _____ ZIP _____

ALLERGIES _____ DIAGNOSIS _____

PRESCRIPTION

PROGESTERONE CREAM
20mg/gm ☐ 30mg/gm ☐ 50mg/gm ☐ _____ mg/gm ☐
Sig: Apply 4 pumps (~ 1gm) topically. Rotate areas of use
☐ Daily before bed (Post-Menopause)
☐ Days 11-25 once at bedtime to inner arms or inner thighs (Pre-Menopause)
Quantity: _____ Refills: 1 2 3 4 5 prn

PROGESTERONE CAPSULE ☐ Slow release (E4M)
25mg ☐ 50mg ☐ 100mg ☐ 150mg ☐ _____ mg ☐
☐ Daily at bedtime (Post-Menopause)
☐ Days 11-25 once at bedtime (Pre-Menopause)
Quantity 30 60 90 Refills: 1 2 3 4 5 prn

PROGESTERONE SUBLINGUAL TABLETS
25mg ☐ 50mg ☐ 100mg ☐ _____ mg ☐
☐ Daily at bedtime (Post-Menopause)
☐ Days 11-25 once at bedtime (Pre-Menopause)
Quantity: 30 60 90 Refills: 1 2 3 4 5 prn

BI-EST E2/E3 (20/80) OR (/) CREAM
0.625mg/gm ☐ 1.25mg/gm ☐ 2.5mg/gm ☐ _____ mg/gm ☐
Sig: Apply 1 gram (4 pumps) every morning except during menstruation (to inner arm or inner thigh)
Quantity: _____ Refills: 1 2 3 4 5 prn

BI-EST E2/E3 (20/80) OR (/) SUBLINGUAL TABLETS
0.625mg ☐ 1.25mg ☐ 2.5mg ☐ _____ mg ☐
Sig: Take 1 tablet sublingually daily every morning
Quantity: 30 60 90 Refills: 1 2 3 4 5 prn

PREGNENOLONE SUBLINGUAL TABLETS
50mg ☐ 100mg ☐ _____ mg ☐
Sig: Take 1 tablet sublingually at bedtime
Quantity: 30 60 90 Refills: 1 2 3 4 5 prn

DHEA SUBLINGUAL TABLETS
5mg ☐ 10mg ☐ 15mg ☐ _____ mg ☐
Sig: Take 1 tablet sublingually every morning
Quantity: 30 60 90 Refills: 1 2 3 4 5 prn

TESTOSTERONE CREAM
1 mg/ml ☐ 2 mg/ml ☐ 4 mg/ml ☐ _____ mg/ml ☐
Sig: Apply 4 pumps (~1gm) topically. Rotate areas of use
Quantity: _____ Refills: 1 2 3 4 5 prn

TESTOSTERONE SUBLINGUAL TABLETS
1mg ☐ 2mg ☐ 3mg ☐ 4mg ☐ 5mg ☐ _____ mg ☐
Sig: Take 1 tablet sublingually every morning
Quantity: 30 60 90 Refills: 1 2 3 4 5 prn

CUSTOM ORDER

RX _____ QUANTITY _____ gm

SIGNATURE _____ REFILL(S) _____

PRESCRIBER

NAME _____ SIGNATURE _____

STREET _____ CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____ ORDER SENT BY _____

DEA LICENSE # _____ STATE LICENSE # _____ NPI # _____

FAX COMPLETED FORM TO **(888) 333-7911**

ACHC PHARMACY COMPOUNDING ACCREDITATION BOARD PCCA PROUD MEMBER