

5 Science Park, Ste 1 New Haven, CT 06511  
 T: 833-497-7370 F: 203-497-7371 Medly Mail NPI: 1740771021

Please detach before submitting to a pharmacy.

**PATIENT INFORMATION:** Complete or include demographic sheet

Full Name:	DOB:	SSN:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Preferred Pronouns:	Primary Language:	
Address:		
City:	State:	Zip:
Phone #:	Alternate Phone #:	
Allergies (Required):	<input type="checkbox"/> NKDA Height:	Weight:
Product Shipping Options: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Alternative Address:		

**PRESCRIBER INFORMATION**

Practice Name:	Office Contact:	
Prescriber Name:	NPI:	DEA:
Practice Address:		
City:	State:	Zip:
Phone #:	Fax #:	

**CLINICAL INFORMATION**

**Diagnosis:**

Strain  Contusion

Sprain  Other:

**In the prescriber's opinion, Flector/Licart is the best treatment option for the patient because:**

The alternatives would not be as effective for treating the patient's condition.

The alternatives would likely have adverse effects.

Patient is stable on current medication and changing to an alternative would likely cause adverse effects.

The oral alternatives are contraindicated for the patient-explain:

Other:

Additional Information:

**Areas Involved:**

Back  Arm  Shoulder

Knee  Neck  Legs

Foot/Calf  Other

**PRIOR MEDICATIONS USED:**

Treatment Type	Strength	Dates of Use
<input type="checkbox"/> Ibuprofen		
<input type="checkbox"/> Diclofenac Oral		
<input type="checkbox"/> Diclofenac Patch		
<input type="checkbox"/> Mefenamic Acid		
<input type="checkbox"/> Indomethacin		
<input type="checkbox"/> Naproxen		
<input type="checkbox"/> Diclofenac Topical		
<input type="checkbox"/> Celecoxib		
<input type="checkbox"/> Etoricoxib		
<input type="checkbox"/> Aspirin		
<input type="checkbox"/> Other:		

**PRESCRIPTION INFORMATION**

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> <b>Flector</b> 15 Patches per Box	<input type="checkbox"/> 1.3% Patch 15 Patches per Box	<input type="checkbox"/> <b>Dose:</b> Apply one patch topically to clean, dry, hairless area BID. <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Box of 15 Patches <input type="checkbox"/> 2 Boxes of 30 Patches	<input type="checkbox"/> _____
<input type="checkbox"/> <b>Licart</b> 30 Patches per Box	<input type="checkbox"/> 1.3% Patch 30 Patches per Box	<input type="checkbox"/> <b>Dose:</b> Apply one patch topically to clean, dry, hairless area once daily. <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Box of 30 Patches <input type="checkbox"/> 2 Boxes of 60 Patches	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

**PRESCRIBER SIGNATURE:** Please sign and date below

**Prescriber Authorization:** By signing below, I hereby authorize the Pharmacy to submit this info to the patient's insurance company/payor for the prescribed medication, including providing a copy of this completed form for any prior authorization request when allowed by the insurance company.

Dispense as written

\_\_\_\_\_  
 Prescriber Signature

\_\_\_\_\_  
 Date

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