Five Star
PHARMACY

Prescription Order Form

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Allergies: _____ **Phone**: (_____) _____

COMPOUNDED MEDICATION

Compounded NAD+ 1% Topical Ointment

Quantity: _____

(max. 12 week supply with 1 refill allowed by law)

Refills: _____

Directions: _____

Compounded NAD+ Reduced SR AR Capsules (acide resistant release)

□ 5 mg
□ capsule size 0
□ capsule size 1
□ 10 mg
□ capsule size 0
□ capsule size 1

Refills: _____

(max. 12 week supply with 1 refill allowed by law)

Directions: _____

Quantity: _____

Prescriber Signature: _____ **Today Date:** _____

Prescriber Printed Name: _____ **□MD □DO □ND □PA □NP □CNM/CN**

State License: _____ **DEA:** _____ **NPI:** _____

Address: _____**City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **E-mail:** _____

We wil call to verify the legitamacy and obtain verbal orders for all controlled substances

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