RX Order Form

Fax to: 800-985-4363

OrigynRx™ Fulfillment Center at AnazaoHealth® Corp

Phone: 800-995-4363 | Fax: 800-985-4363

This prescription will be forwarded to the pharmacy of the patient's choice for fulfillment.
The Prescription Order Form has to be signed by a physician.

Patient Name: ______________________

Address: ______________________

City: ____________ State: ____________

Country: ____________ Zip Code: ____________

☐ Patient will call pharmacy with payment info.

☐ Patient requests Pharmacy to call for payment info.

DOB (m/d/y): ____________ Today's Date: ____________

Telephone: ______________________

Ship to: ☐ Patient ☐ Doctor

Ship Address: ______________________

City: ____________ State: ____ Zip: ____________

Shipping Instructions: ☐ Next Day - $9.00 ☐ 2nd Day - $6.00

The following is a partial list of science-based, commercially available or compounded formulations, used to treat colorectal disease.

Please check box below

Check Here	Product/Medication	Strength	# Weeks Therapy
	Diltiazem Gel*	2% (10 mg per 0.5 ml)	2 Other___
	Nifedipine Gel*	0.2% (1.0 mg per 0.5 ml)	2 Other___
	Glyceryl trinitrate (GTN or NTG)* Ointment (circle strength desired)	0.1% (0.5 mg per 0.5 ml) 0.2% (1.0 mg per 0.5 ml) 0.3% (1.5 mg per 0.5 ml) other: ______%	2 Other___
	Bethanecol Gel	40% (200 mg per 0.5 ml)	2 Other___
	Combination Therapy: Specify	______%______%	2 Other___
	Other: Specify	______%	2 Other___

*DoseRite™ with AccuTip™ delivery system is included with medication - 7 syringes and 21 AccuTips per week of therapy.

SIG. Using DoseRite™ Applicator with AccuTip,™ apply one dose into anal canal three times a day.

Refills: 1 2 3 4 5 Other:_____ Prescriber Signature:______________________

Please check box below

Check Here	Product/Medication	Strength	# Weeks Therapy
	Metronidazole Ointment	10%	2 4 Other___

SIG. Apply one dose three times a day.

Refills: 1 2 3 4 5 Other:_____ Prescriber Signature:______________________

OrigynRx does not make recommendations for prescription medications.

Include 1% LIDOCAINE to prescription ☐

Include lubricant with shipment

(to help with anal insertion of AccuTip)

☐ **YES** - $2.00 ☐ **NO**

Physician Information: (please print)

Prescriber Name: ______________________

Provider #: ______________________

Address: ______________________

____

Telephone: ______________________

Fax: ______________________

Email: ______________________

Patient Payment Information - COD Only

Credit Card Type: ______________________

Cardholder Name: ______________________

Card Number: ______________________

Expiration Date: ______________________

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