PATIENT'S FULL NAME	PHONE NUMBER	AGE	SEX
ADDRESS		DATE OF ISSUANCE / /	

℞

Dr. _____
SIGNATURE OF PRESCRIBER

In order for no substitution to take place, the prescriber shall hand write, ***"Brand Medically Necessary"*** on this prescription blank.

❑ *Refills 1 2 3 4* _____

❑ *No Refills Void After* _____

DEA #: _____

VALID FOR CONTROLLED SUBSTANCES