PATIENT'S FULL NAME	SEX	DATE OF BIRTH / /
ADDRESS		DATE / /

℞

- ☐ 1-24
- ☐ 25-49
- ☐ 50-74
- ☐ 75-100
- ☐ 101-150
- ☐ 151 and over

Units_____

Initials

BRAND MEDICALLY NECESSARY

PRESCRIBER'S SIGNATURE

Refills 1 2 3 4 _____

No Refills Void After _____

DEA #: _____

VALID FOR CONTROLLED SUBSTANCES