Compounded NAD+ Injection Order Form

Clinic Name: _____ Person Faxing: _____

Prescriber Name **(please print)**: _____ NPI: _____

Office Phone: _____ Office Fax: _____

Address: _____ City, State, Zip: _____

Prescriber Signature: _____ Date: _____

Patient Name: _____ DOB:_____

Patient Address: _____ City, State, Zip: _____

Patient Phone #: _____ Drug Allergies: _____

Select One: ☐ Ship/Deliver to Prescriber's Office Address ☐ Ship/Deliver to Patient's Home Address

Select One: ☐ Bill to Prescriber ☐ Bill to Patient

Email for Tracking Information (optional): _____

Rx COMPOUNDED INJECTIONS:

*****Please check box next to prescribed medication, strength, dose & quantity*****

☐ Nicotinamide Adenine Dinucleotide 200 mg/mL – **5 mL vial (1,000 mg)** – Use as directed – Dispense 1 vial

☐ Nicotinamide Adenine Dinucleotide 200 mg/mL – **5 mL vial (1,000 mg)** – _____

Refills: _____