MYERLEE
PHARMACY

# For Joint Pain/Arthralgia

Date: _____

Patient Name: _____

Address: _____City: _____State:_____Zip:_____

Date of Birth: _____Phone:_____

Allergies: _____

Ketoprofen 10%/Indomethacin 10%/Lidocaine 4%
In Lipoderm Activemax

○ 30gm ○ 60gm ○ 90gm

Sig:_____

Refills:_____

Physician Signature: _____

Physician Name: _____License #: _____

Physician Address: _____

Telephone: _____ Facsimile: _____