

BAK Gel Order Form

Please verify contact information is current and correct

Patient Name: _____ Date _____

Address _____

City _____ State _____ Zip _____

Land Line# (_____) _____ Cell Phone #(_____) _____

Sex: Male _____ Female _____ DOB _____

Mailing Address (if different than above) _____

City _____ State _____ Zip _____

Prescription Insurance: **Please enclose a copy of insurance card-front and back.**

Name of Company _____

Processor Control # (PCN) _____ Bin# _____

ID# _____ Group # _____

Cardholder Name _____

Relationship to Cardholder _____

Insurance Phone # (on back of card) _____

Amitriptyline HCl (3.05%)
Baclofen (0.77%)
Ketamine (1.53%)

Base choice Pluronic lecithin organogel (PLO) 30%

Sig: Apply one quarter teaspoon to each area of pain, numbness, or tingling bid. Rub in well.

Quantity: _____ 325 _____ Gm

Prescriber Signature: _____

Address _____

City _____ State _____ Zip _____

DEA _____ Phone _____