



PRESCRIPTION for IMMUNOTHERAPY

Order Form

Fax Rx to 800-811-3389

Customer Service 800-654-3971

Prescriber Information

Account # _____
 Physician name: _____
 Bill to* _____
 Address: _____
 Address: _____
 City, ST Zip _____
 *We do not bill to third party insurance.

Ship to*: Same as bill to.
 Name _____
 Address _____
 Address _____
 City, ST Zip _____
 *We do not ship directly to patients.

Contact: _____
 Phone: _____
 Fax (for confirmations): _____
 E-mail (for confirmations): _____

Patient Information

Patient Name _____
 (First) (MI) (Last)
 Date of Birth _____
 Address (for direct billing)

Payment Information

PO# _____
 Credit Card Number _____
 Visa MC Amex Disc Exp. Date _____

Allow at least 21 days for delivery. This includes a 14-day FDA mandated sterility testing period.

NEW RX

Initial 4-vial Treatment Set(s)
 Vial A - 1:100,000
 Vial B - 1:10,000
 Vial C - 1:1,000
 Vial D - 1:100

Single Vial Maintenance Refill*

Choose either 5ml Vial - **OR** - 10ml Vial
 Rx#(s): _____

 * Prepared as Vial D 1:100 unless otherwise specified.

Special Instructions

List full name of allergens below (i.e. Ragweed, Short) for New Rx Order. No more than 12 allergens will be mixed together in any one treatment set. Allergens will be measured as equal parts unless otherwise specified.

	Prescription #1
1	
2	
3	
4	
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6	
7	
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11	
12	

	Prescription #2
1	
2	
3	
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5	
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7	
8	
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10	
11	
12	

Ordering Physicians Signature _____ **Date** _____