We Care Pharmacy PRESCRIPTION REQUEST FORM – IV THERAPY

PATIENT INFORMATION

Patient Name:_____ DOB:_____
Address:_____ City/State/Zip_____
Phone:_____ Allergies: _____

FORMULATION	CONCENTRATION	VIAL SIZE(S)	# VIALS
O Alpha Lipoic Acid	10mg/mL	30mL	
O Alpha Lipoic Acid	50mg/ml	30mL	
O Biotin	0.5mg/ml	30mL	
O Dexpanthenol	250mg/mL	30mL	
O Edetate Calcium Disodium (PF)	300mg/mL	10mL	
O Folic Acid (commercial product)	5mg/mL	10mL	
O Glutathione	200mg/mL	30mL	
O Glutathione (PF)	200g/mL (PF)	10mL	
O Glycyrrhizic Acid	8mg/mL (PF)	40mL	
O Hydrogen Peroxide	3%	10mL	
O L-Arginine	200mg/mL	30mL	
O L-Carnitine	500mg/ml	30mL	
O L- Lysine	200mg/mL	30mL	
O Magnesium Chloride Hex (PF)	20% (PF)	5mL	
O Magnesium Chloride Hex (commercial product)	20%	50mL	
O Manganese (PF) (commercial product)	1mg/10ml (PF)	10mL	
O Methylcobalamin	5 mg/mL	30mL	
O Methylene Blue (PF)	20mg/ml (PF)	0.75mL	
O N-Acetylcysteine	100mg/mL	10ml	
O NAD+	50mg/mL	20mL	
O NAD+	200 mg/mL	10mL	
O Procaine (SDV)	20mg/mL (SDV)	5mL	
O Phosphatidylcholine 50mg/Sodium Deoxycholate 25mg/ml	50/25 mg/mL	10mL	
O Pyridoxine HCL	100mg/mL	30mL	
O Selenium	200mcg/mL	30mL	
O Sodium Ascorbate	562.5mg/mL (non-GMO)	50mL	
O L-Taurine	50mg/mL	30mL	
O Thiamine (commercial product)	100mg/mL	2mL	
O Vitamin D3	50,000 IU/mL	10mL	
O Zinc Sulfate	10mg/Ml (PF)	30mL	
O Zinc Chloride (commercial product)	1mg/ml (SDV)	10mL	

COMBINATION PRODUCTS	VIAL SIZE(S)	# VIALS
O B-Complex 100	30mL	
O Glycine/Proline/Taurine	30mL	
O Lipotropic-PLUS (IM use)	10mL/50mL	
O Lipotropic-PLUS no lidocaine (IV use)	10mL	
O Lysine/Zinc	1mL	
O MIC	30mL	
O Multi-Trace & Mineral-6	5mL	
O Multi-Amino Acid-6	30mL	
O Myers'-ENHANCED	20mL	
O Myers'-PLUS	20mL	
O Myers'-COMPLETE	20mL	
O Myers'-PUSH	20mL	
O Performance Enhancement	2mL	

IV KITS	TREATMENTS/KIT	# KITS
O Athletic Recovery & Performance Kit	6	
O Detox Kit	3	
O Emergency Plan – Immunity Kit	6	
O Mitochondrial Optimization	4	
O Refresh & Rehydrate Kit	6	
O Youth & Vitality Kit	6	
O Brain Health Kit	3	
O Beauty Replenishing Kit	6	

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O Infuse per provider protocol.

PRESCRIBER INFORMATION

_____
Prescriber Name NPI#
_____
Address City/State/Zip
_____
Phone Fax
Prescriber Signature _____ **Date** _____

All orders are shipped Next Day Air Delivery and have a flat $35 shipping charge

Please send completed form to sales@aestheticrepgroup.com

Credit Card Authorization Form

WeCare Pharmacy is a full-service retail compounding pharmacy and wellness center dedicated to providing personalized one-on-one service and high-quality custom medications to the entire family. Due to the customized nature of the prescriptions dispensed.

WeCare Pharmacy requires payments for all medications to be processed at the time the medication is ordered/requested.

To expedite the order-fulfillment and payment process, please complete the information below. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until the expiration date of the card or until the authorization is revoked.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I certify that I am an authorized user of this credit card. I give permission for Aesthetic Rep Group/WeCare Pharmacy to charge the credit card above for all prescriptions ordered/requested by my facility. I understand that this information will be saved and applied to all future transactions on my account.

Printed Name

Account Name

Signature

Date