



SOUTHERN MARYLAND COMPOUNDING
CENTER PHARMACY

3643 LEONARDTOWN ROAD WALDORF, MD 20601 PHONE (301) 645-2400 FAX (301)476-0382

Patient Name: _____ Date: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Allergies: _____

Day Phone: (_____) _____ Evening Phone: (_____) _____

Testosterone Topical Cream or Gel
Pump container – delivers 1/2 gm doses

Dose (mg/day)	Pump Concentration
<input type="radio"/> 10 mg / day	20mg/gm
<input type="radio"/> 12.5 mg / day	25mg/gm
<input type="radio"/> 15 mg / day	30mg/gm
<input type="radio"/> 20mg/gm	40mg /gm
<input type="radio"/> *25 mg / day	50mg/gm
<input type="radio"/> 30 mg / day	60mg/gm
<input type="radio"/> 35 mg / day	70mg/gm
<input type="radio"/> 40 mg / day	80mg/gm
<input type="radio"/> *50 mg / day	100mg/gm
<input type="radio"/> 100mg/day	Dispensed in pre-filled topical syringes
<input type="radio"/> Other _____ mg/day	

Please Specify

Cream

Gel

Sig: Apply 1 pump (delivers 1/2 gm) topically per day

Qty: 60gm (4 month supply)

Refill _____

*25mg is the amount of testosterone contained in a single AndroGel® 2.5gm packet
*50mg is the amount of testosterone contained in a single AndroGel® 5gm packet

Prescriber Signature: _____

Prescriber Name: _____

Address: _____

City: _____ State: _____ Zip: _____

State License: _____ DEA: _____ (DEA Required for Testosterone)

Phone: (_____) _____ FAX: (_____) _____