

To: **Dynasty Pharmacy**
5460 Yonge St Unit 106
North York, ON-M2N 6K7
Phone: 416-250-5460
Fax: 416-250-5461

Patient Name _____
Address: _____
Date of Birth: _____
PHIN: _____
Today's Date: _____
Phone: _____

Or: _____

Urticaria/Pruritus:

Doxepine 5%, Lidocaine 2% 5% in Xematop

Add: Hydrocortisone 1% 2% ____ % Betamethasone 0.05% 0.1%
Camphor 0.25% 0.5% Aloe vera 0.5% 1%
Ketotifen 0.05%

Directions: Apply QID to affected area(s) (specify area) _____

Mitte: _____grams Refill x _____

Naltrexone 1%, pramoxine 1%, Tranilast 1% in XemaTop

Naltrexone 0.5%, Diphenhydramine 2%, Vitamin D3 5000IU/Gm in Xematop

Add: Hydrocortisone 1% 2% ____ % Betamethasone 0.05% 0.1%
Camphor 0.25% 0.5% Aloe vera 0.5% 1%
Ketotifen 0.05%

Directions: Apply BID to affected area(s) (specify area) _____

Mitte: _____grams Refill x _____

Ketamine* 1% 5% 10%, Amitriptyline 2% 5%, Lidocaine 2% 5% in Xematop

Add: Hydrocortisone 1% 2% ____ % Betamethasone 0.05% 0.1%
Camphor 0.25% 0.5% Aloe vera 0.5% 1%
Ketotifen 0.05%

Directions: Apply BID-TID to affected area(s) (specify area) _____

Mitte: _____grams Refill x _____

Physician Signature: _____

Physician Name (Print): _____

Address / Phone: _____ / _____

Prescription Certification: This prescription represents the original of the prescription. The pharmacy addressee noted above is the only intended recipient and there are no other. The original prescription has been invalidated and securely filed and it will not be transmitted elsewhere at another time.
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