NovaBay®

Avenova®

PHYSICIAN'S NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ NPI: _____

PATIENT'S NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DOB: _____ PHONE: _____ SSN/DL: _____

DIAGNOSIS: _____ ALLERGIES: _____

☐ (1) Avenova Spray 80ml Bottle
QUANTITY: 1 BOTTLE
SIG: 2 SPRAYS APPLIED TWICE A DAY OR AS DIRECTED
REFILLS: ❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑1 YEAR

☐ (2) Avenova Spray 80ml Bottle
QUANTITY: 2 BOTTLES
SIG: 2 SPRAYS APPLIED TWICE A DAY OR AS DIRECTED
REFILLS: ❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑1 YEAR

Special Instructions: ❑ DISPENSE AS WRITTEN / DO NOT SUBSTITUTE

❑ NO SIGNATURE REQUIRED ❑ AUTO REFILL PATIENT INITIALS ☐

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Financial Responsibility: Most patients' insurance plans will cover the drugs listed above. The selected pharmacy will submit all charges to the patients' insuranc
but any charges not covered by the insurance company will be the patient's responsibility.

NovaBay® PHARMA