# TOPICAL ANAESTHETIC

| | | | |
|---|---|---|---|
| Prescriber: | | Patient: | DOB: |
| Address: | | Phone: | Sex: |
| | | Address: | |
| City: | State: Zip: | | |
| Phone: | Fax: | City: | State: Zip: |
| DEA: | NPI: | Email: | |
| Allergies: | | | |

## TOPICAL NUMBING | BENZOCAINE/LIDOCAINE/TETRACAINE

| CHOOSE A FORMULA | QUANTITY | INSTRUCTIONS | REFILLS |
|---|---|---|---|
| ☐ **BLT 20/6/4%** IN **VERSAPRO CREAM** (120 DAYS) | ☐ 30 GM | ☐ APPLY TO AFFECTED AREA 30 MINUTES PRIOR TO PROCEDURE | 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ |
| ☐ **BLT 20/10/4%** IN **OLEA CREAM** (180 DAYS) | | | |
| ☐ **BLT 20/6/4% +DMSO IN VERSA CREAM** (180 DAYS) | | | |
| ☐ **BLT 20/10/10%** IN **VERSA(AB) GEL** (180 DAYS) | | | |
| ☐ **BLT 20/6/4%** IN **EMOLLIENT CREAM** (30 DAYS) | ☐ 60 GM | ☐ APPLY AS DIRECTED PER PROVIDED INSTRUCTIONS | 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ |
| ☐ **LIDO/TETRA 23/7%** **OLEA CREAM** (180 DAYS) | | | |
| ☐ **LIDO/TETRA 23/7%** **PLASTICIZED GEL** (180 DAYS) | | | |
| ☐ **LIDO/TETRA 23/7%** **VERSA(AB) GEL** (180 DAYS) | | | |

Comments:

**PRESCRIBER:**

Signature: _____ Date: ☐☐☐