DEBACTEROL Prescription Authorization:

TO: **Central Pharmacy**
900 Wilshire Blvd, Santa Monica, CA 90401
Phone: 310-395-3294
Toll Free: 855-246-1066
FAX: 866-314-4845

FROM: Prescribing Doctor	
Name: ______________________________	DEA: ______________________
Address: ______________________________	LIC: ______________________
City: ______________________________	NPI: ______________________
State: ________ Zip: __________ Phone: ______________	Fax: ______________________

Patient
Name: ______________________________ Sex: M / F DOB: ______________
Address: ____
City: ______________________________ State: ________ Zip: ______________
Phone: ______________________ eMail: ______________________________

Rx Information	
Medication:	**Debacterol®:** Unit Dose Swab Applicator (0.20mL product)
Directions:	[ ] Use as directed in *Instructions for Use* for acute canker sores
Quantity:	[ ] 1 Single Application Unit
	[ ] 3 Single Application Units
	[ ] 12 Single Application Units (One Box)
Action:	[ ] Authorize This Prescription with: 0 1 2 3 4 refills (select)
	[ ] Authorize __________ times within __________ months.

Authorized By: *(Signature)*	*Date:*
Supervisor: *(If applicable)*	*Date:*