

Provider Name _____

Name _____

Date _____

Address _____

D.O.B. _____

Nicotine gum (check strength)

2mg 4mg

Chew 1 piece every 1-2 hours

Dispense 2 months supply

Flavors Original Orange Mint

Refill NR 1 2 3 4 5 Void after _____

_____ Dispense as Written

_____ May Substitute

Prescription is void if more than one (1) prescription is written per blank.

Provider Name _____

Name _____

Date _____

Address _____

D.O.B. _____

Nicotine patch (check strength)

7mg 14mg 21mg

Apply 1 patch for 16-24 hours each day

Dispense 2 months supply

Refill NR 1 2 3 4 5 Void after _____

_____ Dispense as Written

_____ May Substitute

Prescription is void if more than one (1) prescription is written per blank.