

IVERMECTIN ORDER FORM

Today's Date

3537 N Anthony Blvd
Fort Wayne, IN 46805

(260)373-1083

(260)739-3927

morethanapharmacy@protonmail.com

Patient Information

Patient Name: Date of Birth:
Address: City: State: Zip:
Phone: Email:

Please check
your weight
from one of
these columns

WEIGHT	DOSE
☐ 70-90	8MG
☐ 91-110	10MG
☐ 111-150	13.5MG

WEIGHT	DOSE
☐ 151-190	16MG
☐ 191-210	18MG
☐ 211-230	20MG

WEIGHT	DOSE
☐ 231-250	22MG
☐ 251-270	24MG
☐ 271-290	26MG

WEIGHT	DOSE
☐ 291-310	28MG
☐ Other:	

CHECK ONE BOX BELOW

☐ I HAVE COVID NOW ☐ Using for Cancer ☐ Using for Parasites

I WANT TO ORDER THE FOLLOWING

☐ #15 for \$35.00 Suggested use for COVID Take 2 capsules for 5 days, then 1 every other day until symptoms are gone.

☐ #30 for \$60.00 Or take 1 capsule once or twice a week for prevention

☐ QTY: @ \$1.75 /capsule I would like a different quantity than the options listed above

The pharmacy can not guarantee potency beyond 6 months because clinical trials have not been conducted.

PRESCRIPTION

☐ I do not have a prescription for Ivermectin and need a physician to prescribe it. (Total: \$25.00)

MAIL OPTIONS

☐ I would like to have my order filled and I will pick it up at the pharmacy.
☐ I would like to have my order filled AND mailed (add \$8.00 for standard shipping USPS)
☐ I would like to have my order filled the same day it is received, plus overnight shipping. (Price depends on the address but usually \$30 - \$50)

PLEASE NOTE: We cannot guarantee delivery times because of possible USPS delay that are out of our control. Thanks for understanding. We are happy to help with tracking your package, and we will definitely refund your money if it does not arrive when guaranteed.

Total Billed to Credit Card

Payment Details

Credit Card Type:	☐ VISA ☐ MasterCard ☐ AMERICAN EXPRESS ☐ DISCOVER		
Name on Card		Zip Code:	
Credit Card #			
Exp Date		CCV #	

3-digit number on the back of Visa/MC or 4-digit number on the front of AmEx.

Prescription - Prescriber Use Only

Date: Ivermectin: mg QTY: Refill: 2

☐ **PREVENTION** Take 1 capsule now, then 1 in 48 hours, then 1 capsule weekly for prevention. Quantity: #30 (6 month supply)

☐ **ACTIVE COVID** Take 2 capsules (together) daily for 5 days, then 1 every other day until symptoms are gone. Quantity: #15

☐ **OTHER**

Phil Johnson, MD
3537 N Anthony Blvd
Fort Wayne, IN 46805

Ph: (260) 422-4757
NPI: 1306975263

Dispense As Written

May Substitute

Dr. Philip J. Johnson, M.D.

3537 N Anthony Blvd, Fort Wayne, IN 46805

Phone: (260) 422-4757 | Fax: (260) 422-8375 | Lic.# 01023461

Date Written:

Name:

DOB:

Address:

Phone:

Email:

☐ **Hydroxychloroquine 200mg** (Used as antiviral for Covid)
For severe cases take along with Ivermectin **\$30**

(NDC: 16571-0687-01)

QTY: **#16**

Sig: Take 2 tabs twice daily x 2 days, then 1 tab twice daily x 4 days.

☐ **Z-Pak (Antibiotic)** **\$15**

(NDC: 59762-2198-01)

QTY: **#6**

Sig: 2 now, then 1 tab daily after food x 4 more days. Take at the beginning of Covid to prevent Covid pneumonia.

☐ **Doxycycline 100mg (Antibiotic)** **\$15**

(NDC: 00143-9803-50)

QTY: **#20**

Sig: Take 1 capsule twice daily with food for 10 days.

(Note: Take at the beginning of Covid to prevent pneumonia or sinus infection. This antibiotic is used instead of a Z-Pak if someone has allergies or medical conditions that makes this safer. Hydroxychloroquine and azithromycin taken together can cause problems in some individuals.

☐ **Budesonide Respules 0.25mg/2ml or 0.5mg/2ml or 1mg/2ml** **\$60**
(For use in Nebulizer Machine - Steroid, Anti-inflammatory)

NDC: 00115-1687-74 0.25mg/2ml

NDC: 00093-6816-55 0.5mg/2ml

NDC: 00093-6817-73 1.0mg/2ml

QTY: **#60ml (1 box of 30 x 2ml)**

Sig: Nebulize 1 ampule every 6 hrs as needed for COVID cough and wheeze to decrease inflammation in the lungs.

☐ **Benzonatate 200mg Caps (Cough Suppressant)** **\$15**

(NDC: 64380-0713-07)

QTY: **#12**

Sig: Take 1 capsule every 8 hrs with full glass of water for cough due to COVID

☐ **Ondansetron 4mg tabs** **\$15**
(For nausea & vomiting)

(NDC: 57237-0077-10)

QTY: **#10**

Sig: Dissolve 1 tablet under tongue every 4 hrs to treat COVID related n/v

☐ **Albuterol Inhaler 90mcg/per puff** **\$25**
(Rescue Inhaler for Breathing)

(NDC: 00781-7296-85)

QTY: **#6.7gm (1 inhaler)**

Sig: Inhale 1 or 2 puffs every 4-6 hrs for immediate help with breathing

☐ **Montelukast 10mg tabs** **\$15**
(Leukotriene receptor antagonist to prevent inflammation)

(NDC: 29300-0220-10)

QTY: **#30**

Sig: One tab at bedtime to prevent inflammation in the lungs & nose for COVID or allergies

☐ **Budesonide Nasal Spray 32mcg/spray** **\$20**
(Steroid, Anti-inflammatory for nose and sinus congestion.)

(NDC: 60505-6129-02)

QTY: **#8.43ml (1 inhaler)**

Sig: Use 1 or 2 sprays morning and bedtime in each nostril while sniffing gently for nasal congestion.

☐ **Albuterol Inhalation Nebules (2.5mg/3ml)** **\$15**
(For use in Nebulizer Machine for immediate help with breathing)

(NDC: 00378-8270-52)

QTY: **#75ml (1 box of 25 vials)**

Sig: Nebulize 1 ampule 3 to 4 times a day when needed for immediate relief of COVID related shortness of breath and wheezing.

☐ **Prednisone 20mg Tabs (Steroid, Anti-inflammatory)** **\$15**

(NDC: 00591-544305)

#13

Sig: Take 2 and 1/2 tabs (50mg) first thing in the morning for 5 days.
(Stops inflammation of lungs from Covid that results in breathing difficulties.)

☐ **Other Items Frequently Requested**

Example: Nebulizer, Mucinex, Vitamin C, Vitamin D3, Zinc, Quercetin, Glutathione, NAC, Silver Nasal Spray, RxCofix Nasal Spray, Bronchial Soothe and many other items.

☒ ☐ ☐ ☐ ☐ ☐ ☐

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MEDICAL HISTORY AND ANNUAL PHYSICAL FORM

3537 N Anthony Blvd
Fort Wayne, IN 46805

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(260)739-3927
morethanapharmacy@protonmail.com

Patient Information				Today's Date:															
First:		Last:		DOB:		Phone:													
Please list all allergies: If you are female, are you pregnant now, or planning to become pregnant: ☐ Y ☐ N Have you had COVID, if Yes, list date: _____ ☐ Y ☐ N Have you ever been hospitalized or had an operation? ☐ Y ☐ N Please explain type of surgery and dates: _____																			
If you have more medications or medical history than can fit on the form, please write on the back of this form.																			
MEDICATION NAME--including OTC & herbs				REASON FOR TAKING															
PAST MEDICAL HISTORY				DATE															
MEDICAL CONDITIONS				Legend: PR=Present, PA=Past															
1.GENERAL		PR	PA	6.CARDIOVASCULAR		PR	PA	9.MUSCULOSKELETAL		PR	PA								
Weight Loss		☐	☐	Chest Pain		☐	☐	Joint Pain		☐	☐								
Fatigue		☐	☐	Irregular Heart Beat		☐	☐	Joint Swelling		☐	☐								
Memory Loss		☐	☐	Elevated Blood Pressure		☐	☐	Jaw Pain		☐	☐								
2.HEENT		PR	PA	Heart Disease		☐	☐	10.NEUROLOGICAL		PR	PA								
Headache		☐	☐	Shortness of Breath		☐	☐	Blackouts		☐	☐								
Visual Loss		☐	☐	Swelling of Limbs		☐	☐	Dizziness		☐	☐								
Decreased Hearing		☐	☐	7.ENDOCRINOLOGY		PR	PA	Seizures		☐	☐								
Sinus Pain		☐	☐	Diabetes		☐	☐	Stroke		☐	☐								
Hoarseness		☐	☐	Excessive Thirst		☐	☐	11.PSYCHIATRIC		PR	PA								
Sore Throat		☐	☐	Excessive Urination		☐	☐	Anxiety		☐	☐								
Trouble Swallowing		☐	☐	Libido Change		☐	☐	Depression		☐	☐								
3.RESPIRATORY		PR	PA	8.GASTROINTESTINAL		PR	PA	Sleep Issues		☐	☐								
Cough		☐	☐	Bloody Stool		☐	☐	12a. MALE/Genitourinary		PR	PA								
Wheezing		☐	☐	Constipation		☐	☐	Urinary Dribbling		☐	☐								
4.BREAST		PR	PA	Diarrhea		☐	☐	Reduced Flow		☐	☐								
Breast Mass		☐	☐	Heart Burn		☐	☐	Nighttime Urination		☐	☐								
Breast Pain		☐	☐	Jaundice		☐	☐	12b. FEMALE/Genitourinary		PR	PA								
Skin Changes		☐	☐	Kidney Stones		☐	☐	Abnormal Pap Smear		☐	☐								
5.HEMATOLOGY		PR	PA	Nausea		☐	☐	Urinary Complaints		☐	☐								
Anemia		☐	☐	Vomiting		☐	☐	Blood in Urine		☐	☐								
Bleeding Issues		☐	☐					Menstrual Irregularities		☐	☐								
☐ I have none of the above medical conditions																			
SOCIAL HISTORY				MISC.				TELEMEDICINE CONSULTATION											
								Reviewed by Dr. Phil Johnson											
1.Smoking				CONDITION								Y				N			
Never ☐ Present ☐ Past ☐ Pack Years: _____				Hepatitis A								☐				☐			
				Hepatitis B								☐				☐			
2.Alcohol				COPD or Emphysema								☐				☐			
Drinks per day: _____				Cancer				☐				☐							
3.Drugs				OTHER: _____				☐				☐							
☐																			

To the best of my knowledge this is a complete and accurate account of my medical history.

Signature: _____ Date: _____

I acknowledge and understand that Ivermectin has been deemed “Highly Not Recommended” by the WHO, FDA, CDC, and NIH. I acknowledge that my Clinicians rely on an appropriate medical and medication history relating to medical conditions and prescribed medications as reported by me as a patient.

Should a patient choose to not disclose their proper medical history, the clinician cannot be held liable nor can any medical license in any state be reviewed or held accountable. We will be explaining, to the best of our ability, the risks in prescribing any medications to the patients to which they must state they understand.

I understand that Ivermectin has not been approved for use for Covid 19 by the FDA at this time

**Patient
Signature**

Print Name