

IVERMECTIN ORDER FORM

Today's Date

3537 N Anthony Blvd
Fort Wayne, IN 46805

(260) 373-1083

(260) 739-3927

3riverspharmacy@gmail.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 | WEIGHT | DOSE | WEIGHT | DOSE | WEIGHT | DOSE |
|----------------------------------|--------|----------------------------------|------|----------------------------------|------|---------------------------------------|------|
| <input type="checkbox"/> 70-90 | 8MG | <input type="checkbox"/> 151-190 | 16MG | <input type="checkbox"/> 231-250 | 22MG | <input type="checkbox"/> 291-310 | 28MG |
| <input type="checkbox"/> 91-110 | 10MG | <input type="checkbox"/> 191-210 | 18MG | <input type="checkbox"/> 251-270 | 24MG | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> 111-150 | 13.5MG | <input type="checkbox"/> 211-230 | 20MG | <input type="checkbox"/> 271-290 | 26MG | | |

CHECK ONE BOX BELOW

I HAVE COVID NOW I DO NOT HAVE COVID NOW I am not using this for COVID

I WANT TO ORDER THE FOLLOWING

#15 for \$30.00 Active Covid Protocol Take 2 capsules for 5 days, then 1 every other day until symptoms are gone.

#30 for \$50.00 Prevention Protocol Take 1 capsule weekly. (30 Capsules = 6 months)

QTY: @ \$1.65 /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 the same day it is received and I will pick it up at the pharmacy.

I would like to have my order filled the same day it is received AND mailed same day. (add \$5.00 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 - \$40)

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: 1yr

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 Ph: (260) 422-4757
3537 N Anthony Blvd NPI: 1306975263
Fort Wayne, IN 46805

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 (For use in Nebulizer Machine - Steroid, Anti-inflammatory)

\$30

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 (For nausea & vomiting)

\$15

(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 (Rescue Inhaler for Breathing)

\$25

(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 (Leukotriene receptor antagonist to prevent inflammation)

\$15

(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 (Steroid, Anti-inflammatory for nose and sinus congestion.)

\$16

(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) (For use in Nebulizer Machine for immediate help with breathing)

\$15

(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.

Refill NR 1 2 3 4 5 1yr

Void 1 year from the date written

Dispense as Written

May Substitute

MEDICAL HISTORY AND ANNUAL PHYSICAL FORM

3537 N Anthony Blvd
Fort Wayne, IN 46805

(260) 373-1083
(260) 739-3927
covid.care.now@gmail.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 | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | Joint Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heart Beat | <input type="checkbox"/> | <input type="checkbox"/> | Joint Swelling | <input type="checkbox"/> | <input type="checkbox"/> |
| Memory Loss | <input type="checkbox"/> | <input type="checkbox"/> | Elevated Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.HEENT | PR | PA | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | 10.NEUROLOGICAL | PR | PA |
| Headache | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | Blackouts | <input type="checkbox"/> | <input type="checkbox"/> |
| Visual Loss | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of Limbs | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| Decreased Hearing | <input type="checkbox"/> | <input type="checkbox"/> | 7.ENDOCRINOLOGY | PR | PA | Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus Pain | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Hoarseness | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst | <input type="checkbox"/> | <input type="checkbox"/> | 11.PSYCHIATRIC | PR | PA |
| Sore Throat | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Urination | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| Trouble Swallowing | <input type="checkbox"/> | <input type="checkbox"/> | Libido Change | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.RESPIRATORY | PR | PA | 8.GASTROINTESTINAL | PR | PA | Sleep Issues | <input type="checkbox"/> | <input type="checkbox"/> |
| Cough | <input type="checkbox"/> | <input type="checkbox"/> | Bloody Stool | <input type="checkbox"/> | <input type="checkbox"/> | 12a. MALE/Genitourinary | PR | PA |
| Wheezing | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | <input type="checkbox"/> | Urinary Dribbling | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.BREAST | PR | PA | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | Reduced Flow | <input type="checkbox"/> | <input type="checkbox"/> |
| Breast Mass | <input type="checkbox"/> | <input type="checkbox"/> | Heart Burn | <input type="checkbox"/> | <input type="checkbox"/> | Nighttime Urination | <input type="checkbox"/> | <input type="checkbox"/> |
| Breast Pain | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | 12b. FEMALE/Genitourinary | PR | PA |
| Skin Changes | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Pap Smear | <input type="checkbox"/> | <input type="checkbox"/> |
| 5.HEMATOLOGY | PR | PA | Nausea | <input type="checkbox"/> | <input type="checkbox"/> | Urinary Complaints | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | Blood in Urine | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding Issues | <input type="checkbox"/> | <input type="checkbox"/> | | | | Menstrual Irregularities | <input type="checkbox"/> | <input type="checkbox"/> |

I have none of the above medical conditions

| SOCIAL HISTORY | | | | MISC. | | | TELEMEDICINE CONSULTATION | |
|-----------------------|--------------------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|------------------------------|--|
| | Never | Present | Past | CONDITION | Y | N | Reviewed by Dr. Phil Johnson | |
| 1.Smoking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Pack Years: _____ | | | | Hepatitis B | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 2.Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | COPD or Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Drinks per day: _____ | | | | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 3.Drugs _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | OTHER: _____ | <input type="checkbox"/> | <input type="checkbox"/> | | |

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 _____