SAMPLE PRESCRIPTION FOR ALLERGY PATIENTS (EDIT AS NEEDED)

**NAME OF PRACTICE**

Address Tel #: Fax #:

City, State Zip Code

PRESCRIBER LICENSE # DEA #

Rx

#1 EpiPen Auto-Injector (0.3 mg epinephrine injection) OR GENERIC EQUIVALENT

 Refil(s) 0 1 2 3 4 5

# #1 BD Veo™ insulin syringes with BD Ultra-Fine™6mm x 31G needle

# OR GENERIC EQUIVALENT OR SIMILAR

 Refil(s) 0 1 2 3 4 5