

Patient Information:			PLEASE FAX Patient Demographic Sheet & Prescription Insurance Card if available.		
FIRST NAME:	LAST NAME:	DATE OF BIRTH:			
PRIMARY PHONE #: <input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK	SECONDARY PHONE #: <input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK	LAST 4 DIGITS OF SSN:			
ADDRESS:	CITY, STATE, ZIP:	ALLERGIES:			

Rx Medication Order:	Pharmacist Please Compound:	<i>Prescriber: You may change the directions, or delete / substitute / add any additional medications for all formulations.</i>
*Rph: please compound the Rx order free of any gluten, casein, dyes, sulfates and parabens.		
<input type="checkbox"/> # 31 Formula Testosterone*		Directions: _____
Select Strength (per gram of base):	Select Quantity:	
<input type="checkbox"/> 25mg (2.5%) <input type="checkbox"/> 50mg (5%) <input type="checkbox"/> 75mg (7.5%)	<input type="checkbox"/> 30gm (thirty grams) <input type="checkbox"/> 60gm (sixty grams)	
<input type="checkbox"/> 100mg (10%) <input type="checkbox"/> 125mg (12.5%) <input type="checkbox"/> 150mg (15%)	<input type="checkbox"/> 90gm (ninety grams) <input type="checkbox"/> Other : _____	
<input type="checkbox"/> Other: _____		
Select Base:		Refills: _____
<input type="checkbox"/> Cream <input type="checkbox"/> Gel		

TRANSDERMAL CREAMS:		
<input type="checkbox"/> BI-EST Cream	Check one Dose: <input type="checkbox"/> 0.75mg/gm <input type="checkbox"/> 1.25mg/gm <input type="checkbox"/> 2.5mg/gm <input type="checkbox"/> 5mg/gm <input type="checkbox"/> 10mg/gm <input type="checkbox"/> ____mg/gm	
Select BI-EST Ratio of Estriol (E ₃) : Estradiol (E ₂)	<input type="checkbox"/> (80:20) <input type="checkbox"/> (50:50) <input type="checkbox"/> (10:90)	Note: If no selection, fill (80:20)
<input type="checkbox"/> Progesterone Cream	Check one Dose: <input type="checkbox"/> 10mg/gm <input type="checkbox"/> 20mg/gm <input type="checkbox"/> 30mg/gm <input type="checkbox"/> 40mg/gm <input type="checkbox"/> 50mg/gm	
	<input type="checkbox"/> 100mg/gm <input type="checkbox"/> 150mg/gm <input type="checkbox"/> 200mg/gm <input type="checkbox"/> ____mg/gm	
<input type="checkbox"/> Custom Blended Cream	Estriol ____ mg/gm, Estradiol ____ mg/gm, Progesterone ____ mg/gm, Testosterone ____ mg/gm	
SIG: <input type="checkbox"/> Apply 1gm to upper/inner arm once daily	QTY: <input type="checkbox"/> 30gm <input type="checkbox"/> 60gm <input type="checkbox"/> 90gm	
<input type="checkbox"/> Apply 1gm to alternating breasts daily for 6 days and on the 7th day apply 1gm to face. Repeat every week.		Refills: _____
<input type="checkbox"/> _____		

<input type="checkbox"/> Compounded Progesterone Oral Troche
Select Strength: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg <input type="checkbox"/> 200mg <input type="checkbox"/> ____mg
Select Quantity: <input type="checkbox"/> 30 troches <input type="checkbox"/> 90 troches
SIG: Place 1 troche between cheek and gum until dissolves completely once daily. Do not chew or swallow whole. Refills: _____

<input type="checkbox"/> Compounded Progesterone Capsules
Select Strength: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> 75mg <input type="checkbox"/> ____mg
Select Quantity: <input type="checkbox"/> 30 caps <input type="checkbox"/> 90 caps <input type="checkbox"/> 30 caps <input type="checkbox"/> 90 caps
SIG: Take 1 cap at bedtime to relieve insomnia. Refills: _____

<input type="checkbox"/> Nitroglycerin 0.5% + Lidocaine 5%
QTY (gm): <input type="checkbox"/> 30gm <input type="checkbox"/> 60gm <input type="checkbox"/> 90gm
SIG: Apply 0.5gm (pea size amount) to anal fissure once to twice daily Refills: _____

(OPTIONAL) ADDITIONAL INSTRUCTIONS or COMPOUNDS:

*Price Disclaimer: Prices may change without notice due to price fluctuations of raw materials.

Additional Formulas are available. Please contact the Pharmacist at (855) 246-6338.

Prescriber Information:	
PRESCRIBER'S SIGNATURE:	
PRESCRIBER NAME (PRINT):	
NPI# or DEA# (CTP# for CNPs only):	DATE:

Contact Information:		
ADDRESS:		
CITY:	STATE:	ZIP:
PHONE #:	FAX #:	

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PRIMARY PHONE #: CELL HOME WORK SECONDARY PHONE #: CELL HOME WORK LAST 4 DIGITS OF SSN: _____

ADDRESS: _____ CITY, STATE, ZIP: _____ ALLERGIES: _____

Rx Medication Order: Pharmacist Please Compound: *Prescriber: You may change the directions, or delete / substitute / add any additional medications for all formulations.*

*** Hair Loss Treatment - Male**

H5. Formula

Minoxidil 10% (Rogaine)
Azelaic acid 2% **New!**
Ketoconazole 2%
Tea Tree oil 0.25%
Finasteride 0.25% (Propecia)

QTY: 100ml/\$89 200ml/\$149

SIG: Apply 20-30 drops daily into scalp area of hair loss (1-2 hours) before bedtime.

Refills: _____

*** Hair Loss Treatment - Female**

H6. Formula

Minoxidil 10% (Rogaine)
Azelaic acid 2% **New!**
Ketoconazole 2%
Tea Tree oil 0.25%
Finasteride 0.1% (Propecia)
Progesterone 1%

QTY: 100ml/\$95 200ml/\$159

SIG: Apply 20-30 drops daily into scalp area of hair loss (1-2 hours) before bedtime.

Refills: _____

*** Wart Treatment**

Formula X5
(formerly known as 15-L)

Salicylic acid 60% +
Cimetidine 5% +
Trichloroacetic acid 1% +
Ibuprofen 2%

QTY (gm): 25/\$39 50/\$49 75/\$59

Refills: _____

SIG: Apply 1-2 grams to affected area 1-2 times daily

*** Nail Fungus**

Formula X10
(formerly known as CF-1)

Urea 40% +
Salicylic acid 10% +
Ibuprofen 2% +
Ketoconazole 2% +
Tea Tree oil 0.5%

QTY: 10ml/\$39

Refills: _____

SIG: Apply to affected nail(s) at bedtime, let air dry for 2 minutes.

*** Skin Lightening**

21. Formula

Tretinoin 0.05%
Desonide 0.05%
Hydroquinone: 3% 4%
 6% 8% or _____

QTY: 30gm/\$59 60gm/\$89

Refills: _____

SIG: Apply to affected areas (dark spots) 30 min. before bedtime

*** Numbing Cream**

29BLT. Formula

Benzocaine 20%
Lidocaine 6%
Tetracaine 4%

QTY: 30gm/\$35 60gm/\$55

Refills: _____

SIG: Apply 2-4gm as directed by physician

*** Pain**

5. Formula

Diclofenac sod 3%
Gabapentin 6%
Lidocaine 2% + Prilocaine HCl 2%

QTY (gm): 240 120

Refills: _____

SIG: Apply 1-2gm topically to affected area TID-QID

*** Anti-wrinkle**

77. Formula

Tretinoin 0.05% + Kojic acid 2%
Niacinamide 2% + Vitamin C 5%
Vitamin E acetate 2%

QTY: 60gm/\$79 120gm/\$129

Refills: _____

SIG: Apply 0.5-1gm daily 1 hour before bedtime.

*** Anti-aging * Anti-wrinkle**

R7. Formula

Ascorbic acid 10%
Azelaic acid 5%
Alpha Lipoic acid 1%
Estriol 0.1%
Progesterone 2%

QTY: 60gm/\$65 120gm/\$99

Refills: _____

SIG: Wash face, dry and apply daily at bedtime

(OPTIONAL) ADDITIONAL INSTRUCTIONS or COMPOUNDS:

Clicker (\$6 extra per clicker)

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