

ONYCHOMYCOSIS

Prescription Order Form

Please Fax to:
(877) 791-7779

Patient Information:

PLEASE FAX with Patient Demographic Sheet & Rx Insurance Card

REQUIRED	FIRST NAME:	LAST NAME:	Additional Info	ADDRESS:	
	PRIMARY PH #:	SECOND PH #:		CITY, STATE, ZIP:	
	DATE OF BIRTH:	ALLERGIES:		EMAIL ADDRESS:	LAST 4 DIGITS OF SSN:

Rx Medication Order:

Pharmacist Please Compound:

Prescriber: You may change the directions, or delete / substitute / add any additional medications for all formulations.

11C Formula

Itraconazole 1% + Terbinafine HCl 2% +
Ibuprofen 2% In DMSO polish

Quantity: 15mL/\$34.99 30mL/\$59.99

Sig: Brush on affected nail(s) BID.

Refill: _____

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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