GENERAL MEDICINE

Prescription Order Form

PH: (855) 246-6338
Please Fax to:
(877) 791-7779

Patient Information:

PLEASE FAX with Patient Demographic Sheet & Rx Insurance Card

REQUIRED

FIRST NAME: **LAST NAME:**

PRIMARY PH #: **SECOND PH #:**

DATE OF BIRTH: ☐ **Check here** if this is a Worker's Comp or Auto Claim prescription.

ALLERGIES:

Additional Info

ADDRESS:

CITY, STATE, ZIP:

EMAIL ADDRESS:

LAST 4 DIGITS OF SSN:

Rx Medication Order:

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

Pain Management & Neuropathy*

☐ **# 5. Formula**
Diclofenac sodium 3%
Gabapentin 6%
Lidocaine 2%
Prilocaine HCl 2%
QTY (gm): ☐240 ____ Other
SIG: Apply 1-2gm topically to affected area TID-QID
Refill: ____

☐ **# 5U. Formula**
Ketamine HCl 5% + Diclofenac sod 5%
Gabapentin 6% + Amitriptyline HCl 2%
Cyclobenzaprine HCl 2%
Magnesium chloride hexahydrate 3%
QTY (gm): ☐240 ____ Other
SIG: Apply 1-2gm topically to affected area TID-QID
Refill: ____

☐ **# 8D. Formula**
Diclofenac sodium 3%
Gabapentin 6%
Dimethyl Sulfoxide (DMSO) 10%
Amitriptyline HCl 2%
Cyclobenzaprine HCl 2%
Lidocaine 4%
QTY (gm): ☐240 ____ Other
SIG: Apply 1-2gm topically to affected area TID-QID
Refill: ____

Neuropathy Rx Cream*

☐ **Verapamil**
Verapamil HCl: ☐10% ☐15%
☐ Add 5% Lidocaine
QTY (gm): ☐120 ☐240 ____ Other
SIG: Apply 1-2gm topically to affected area TID-QID
Refill: ____

Neuropathy Suppl. / OTC*

☐ **Neuro-B 800**

Vitamin B-2 25mg
Vitamin B-6 25mg
Folate 800mcg
(5-MTHF 400mg + Folinic Acid 400mg)
Vitamin B-12 1,000mcg
Trimethylglycine 500 mg
QTY: 60 capsules
SIG: Use as directed by your physician/pharmacist
Refill: ____

Hormone Therapy*

☐ **# 31. Formula**
Testosterone micronized:
(amt per gm of base)
☐ 5% ☐ 7.5% ☐ 10% ☐ ____ Other
Base: ☐ Cream ☐ Gel
QTY (gm): ☐ 30 ☐ 90 ____ Other
SIG: Apply 1gm topically to upper arms or shoulders QAM
Refill: ____

Nausea & Vomiting*

☐ **# 64. Formula**
Promethazine HCl 2.5%
QTY (gm): ☐120 ____ Other
SIG: Apply 1/2 to 1gm to inner wrist every q 4-6 h prn nausea/vomiting
Refill: ____

Hemorrhoids*

☐ **# 51. Suppository**
Hydrocortisone 1%
Lidocaine 2%
QTY: ☐ 24 Sup. ____ Other
SIG: Insert suppository at bedtime AD
Refill: ____

Onychomycosis*

☐ **# 11C. Formula**
Itraconazole 1% +
Terbinafine HCl 2% +
Ibuprofen 2% In DMSO polish
QTY (ml): ☐15ml/$34.99
☐ 30ml/$59.99
SIG: Brush on affected nail(s) BID
Refill: ____

Keratolytic*

☐ **# 12C. Formula**
Urea 20% + Lactic Acid 2%
Salicylic Acid 5%
Vitamin E acetate 1%
Ciclopirox olamine 0.55%
QTY (gm): ☐240 ☐480 ____ Other
SIG: Apply 2-4gm topically to affected area TID-QID
Refill: ____

Skin Lightening*

☐ **# 21. Formula**
Tretinoin 0.05% + Desonide 0.05% +
Hydroquinone:
☐ 3% ☐ 4% ☐ 5% ☐ ____ Other
QTY: ☐30gm/$59
☐60gm/$89
SIG: Apply on affected areas (dark spots) 30 min. before bedtime.
Refill: ____

Anti-Wrinkle*

☐ **# 77. Formula**
Tretinoin 0.05% + Kojic Acid 2%
Niacinamide 2% + Vitamin C 5%
Vitamin E Acetate 2%
QTY: ☐ 60gm/$79
☐120gm/$129
SIG: Apply 0.5-1gm daily 1 hour before bedtime.
Refill: ____

Scar & Wound*

☐ **# 144B. Formula**
Vancomycin HCl 1%
Gentamicin sulfate 0.1%
Mupirocin 0.5%
Metronidazole 0.5%
QTY (gm): ☐60 ☐120 ____ Other
SIG: Apply 1-2gm topically to affected area BID
Refill: ____

Skin Moisturizer*

☐ **# 13B. Formula**
Desoximetasone 0.125%+ Urea 5% +
☐ Opt. 1: Ammonium Lactate 3%
☐ Opt. 2: in Moisturizing Base
☐ Opt. 3: Ciclopirox 0.2%
QTY (gm): ☐120 ☐240 ____ Other
SIG: Apply 2-4gm topically to affected area BID
Refill: ____

Warts*

☐ **# 32 Formula**
Cantharidin 0.7% Topical Liquid
QTY (mL): ☐ 2mL/$39 (2-3 month supply)
☐ 5mL/$79 (4-6 months supply)
SIG: To be applied by **physician only**. Bring to your physicians office for **physician administration only.**
Refill: ____

(OPTIONAL) ADD-ON INGREDIENTS:

CHECK ONE OF THE FOLLOWING TO ADD ON TO ANY FORMULA

☐ Amantadine HCl 8% (NMDA Antagonist)
☐ Orphenadrine citrate 5% (NMDA Antagonist)
☐ Desoximetasone 0.25% (Steroid)
☐ Dimethyl Sulfoxide (DMSO) 5% (Penetrant Enhancer)
☐ Clonidine HCl 0.2% (Sympathetic)
☐ Cyclobenzaprine HCl 2% (Muscle Relaxer)
☐ Nifedipine 5% (Vasodilator)
☐ ____ : ____%

☑ ***I, the prescriber signing below, authorize the pharmacist to change to a compound covered by the patient's third-party insurance.***
To uncheck this statement box please initial here ____

*** Commonly prescribed for the indicated condition.**

Prescriber Information:

PRESCRIBER'S SIGNATURE:

PRESCRIBER NAME (PRINT):

NPI# or DEA# (CTP# for CNPs only): DATE:

Contact Information:

ADDRESS:

CITY: STATE: ZIP:

PHONE #: FAX #:

The information provided herein is for reference only and is not to be relied upon as making any representation as to the efficacy of any particular formulations. Nothing herein is intended to replace the independant judgement of a licensed professional. This form is proprietary of Pharmacy Venture Consultants, LLC and is only intended for use between provider and patient. Any unauthorized use could result in legal action.This facsimile transmission is intended to be delivered to the named addressee and may contain information that is confidential, privileged, and proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the names addressee, the recipient should immediately notify the sender at the address and/or telephone number set forth herein and obtains instructions as to the disposal of the transmitted material. In no event should such material be read or retained by anyone other than the addressee, except by express authority of the sender to the named addressee. As always, the FDA does not review any compounded medication for safety of efficacy.