Dermatology Compounding

Patient Information

Patient Name:	Date of Birth:	☐ Male ☐ Female	
Address:	City:	State:	Zip:
Phone:	Email:	Language:	
Allergies:			☐ NKDA

☐ Pick Up / Ship to: ☐ Patient ☐ Office ☐ Alternative Address:

** By providing your mobile phone number you agree to receive a text message from with instructions and steps to provide payment for your medication. This is not advertising.

Insurance: Please fax copy of insurance card (front and back)

Prescriber Information

Practice Name:	Office Contact:		
Prescriber:	NPI:	DEA:	
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information

Diagnosis:	ICD-10:

Compounded Prescription Information

Compound	Dose	Directions	Quantity	Refills
Scarring				
☐ Tamoxifen/Tranilast/Caffeine in PracaSil Plus™	0.1%/1%/0.1%	Apply 1 pump topically to affected area ☐ QD ☐ BID (1 pump = 1 mL)	☐ 30 g ☐ 60 g	
Stretch Marks and Acne				
☐ Tretinoin in PracaSil Plus™	☐ 0.025% ☐ 0.1% ☐ Other:	Apply 1 pump topically to affected area ☐ QD ☐ BID (1 pump = 1 mL)	☐ 30 g ☐ 60 g	
Numbing				
☐ Benzocaine/Lidocaine/Tetracaine	☐ 20%/8%/4%	Apply ____ hours before procedure	☐ 30 g ☐ 60 g	
	☐ 10%/4%/2%	To be applied in physician's office		
Bleaching				
☐ Hydroquinone	☐ 8%	Apply topically to affected area ☐ HS ☐ BID	☐ 30 g ☐ 60 g	
☐ Hydroquinone/Tretinoin/Fluocinolone	☐ 10%/0.05%/0.01%			
Facial Peels				
☐ Trichloroacetic Acid	☐ 20% ☐ 40% ☐ 60% ☐ 70% ☐ Other _____	To be applied during office procedure	☐ 30 mL ☐ 60 mL	
Hyperhidrosis				
☐ Aluminum Chloride Hexahydrate	☐ 20%	Apply topically to affected area ☐ BID ☐ TID	☐ 120 mL ☐ 240 mL	
Wart Medications				
☐ Cantharidin Plus Solution (Cantharidin/Podophyllin Resin/Salicylic Acid)	0.1%/0.5%/30%	To be applied during office procedure		
Shingles				
☐ Acyclovir/Gabapentin/Amitriptyline/Lidocaine	10%/6%/2%/5%	Apply 1 pump (1ml) topically to affected area 3-4 times a day	☐ 60g ☐ 90g	
Custom Formula				
☐				

Prescriber Signature and Date (Please sign and date below)

_____

Prescriber Signature Date

Check here to authorize the receiving pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber's behalf. "I certify that the above therapy is medically necessary, and the above information is accurate to the best of my knowledge"