

Dermatology Compounding

Patient Information				
Patient Name:			Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		City:	State:	Zip:
Phone:	Email:		Language:	
Allergies:				<input type="checkbox"/> NKDA
<input type="checkbox"/> Pick Up / Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Office <input type="checkbox"/> Alternative Address: <small>** 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.</small>				
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				
<input type="checkbox"/> Tamoxifen/Tranilast/Caffeine in PracaSil Plus™	0.1%/1%/0.1%	Apply 1 pump topically to affected area <input type="checkbox"/> QD <input type="checkbox"/> BID (1 pump = 1 mL)	<input type="checkbox"/> 30 g <input type="checkbox"/> 60 g	
Stretch Marks and Acne				
<input type="checkbox"/> Tretinoin in PracaSil Plus™	<input type="checkbox"/> 0.025% <input type="checkbox"/> 0.1% <input type="checkbox"/> Other:	Apply 1 pump topically to affected area <input type="checkbox"/> QD <input type="checkbox"/> BID (1 pump = 1 mL)	<input type="checkbox"/> 30 g <input type="checkbox"/> 60 g	
Numbing				
<input type="checkbox"/> Benzocaine/Lidocaine/Tetracaine	<input type="checkbox"/> 20%/8%/4%	Apply ____ hours before procedure	<input type="checkbox"/> 30 g	
	<input type="checkbox"/> 10%/4%/2%	To be applied in physician's office	<input type="checkbox"/> 60 g	
Bleaching				
<input type="checkbox"/> Hydroquinone	<input type="checkbox"/> 8%	Apply topically to affected area <input type="checkbox"/> HS <input type="checkbox"/> BID	<input type="checkbox"/> 30 g	
<input type="checkbox"/> Hydroquinone/Tretinoin/Fluocinolone	<input type="checkbox"/> 10%/0.05%/0.01%		<input type="checkbox"/> 60 g	
Facial Peels				
<input type="checkbox"/> Trichloroacetic Acid	<input type="checkbox"/> 20% <input type="checkbox"/> 40% <input type="checkbox"/> 60% <input type="checkbox"/> 70% <input type="checkbox"/> Other _____	To be applied during office procedure	<input type="checkbox"/> 30 mL <input type="checkbox"/> 60 mL	
Hyperhidrosis				
<input type="checkbox"/> Aluminum Chloride Hexahydrate	<input type="checkbox"/> 20%	Apply topically to affected area <input type="checkbox"/> BID <input type="checkbox"/> TID	<input type="checkbox"/> 120 mL <input type="checkbox"/> 240 mL	
Wart Medications				
<input type="checkbox"/> Cantharidin Plus Solution (Cantharidin/Podophyllin Resin/Salicylic Acid)	0.1%/0.5%/30%	To be applied during office procedure		
Shingles				
<input type="checkbox"/> Acyclovir/Gabapentin/Amitriptyline/Lidocaine	10%/6%/2%/5%	Apply 1 pump (1ml) topically to affected area 3-4 times a day	<input type="checkbox"/> 60g <input type="checkbox"/> 90g	
Custom Formula				
<input type="checkbox"/>				
Prescriber Signature and Date (Please sign and date below)				
Prescriber Signature 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"				Date

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