

Urogynecology 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: ** 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
Spasms				
<input type="checkbox"/> Baclofen/Lidocaine Vaginal Suppositories <i>*if you would like to use Lorazepam 2 mg, it must be written in the custom box below*</i>	4 mg/2%	Insert 1 suppository intravaginally QD HS	<input type="checkbox"/> 30 Suppositories <input type="checkbox"/> Other:	
Painful Urination/Thinning of Vaginal Tissue				
<input type="checkbox"/> Estriol Cream <input type="checkbox"/> DHEA 6.5mg	5mg/g	Insert 1g intravaginally QD HS as directed	<input type="checkbox"/> 30 g <input type="checkbox"/> Other:	
<input type="checkbox"/> Estradiol/Lidocaine/Aloe <input type="checkbox"/> DHEA 6.5mg	0.01%/2%	Insert 1g intravaginally QD HS as directed	<input type="checkbox"/> 30 g <input type="checkbox"/> Other:	
<input type="checkbox"/> Estradiol in HRT Base <input type="checkbox"/> DHEA 6.5mg <i>*if you would like to use testosterone 0.025%, it must be written in custom box below*</i>	0.005%	Insert 1g intravaginally QD HS as directed	<input type="checkbox"/> 30 g <input type="checkbox"/> Other:	
Vulvodynia				
<input type="checkbox"/> BLT (Benzocaine / Lidocaine / Tetracaine)	10% / 5% / 2%	Apply 1 pump (1ml) topically 1-2 times a day as directed.	<input type="checkbox"/> 60 g <input type="checkbox"/> Other: (1 pump = 1ml)	
<input type="checkbox"/> Amitriptyline/Baclofen in Lipoderm Base	2%/2%	Apply 1 pump (1ml) topically 1-2 times a day as directed.	<input type="checkbox"/> 60 g <input type="checkbox"/> Other: (1 pump = 1 ml)	
<input type="checkbox"/> Ketoprofen/Gabapentin/Lidocaine in HRT Base	10%/6%/5%	Apply 1 pump (1ml) topically 1-2 times a day as directed.	<input type="checkbox"/> 60 g <input type="checkbox"/> Other (1 pump = 1 ml)	
<input type="checkbox"/> Atropine/Estradiol in HRT Base <i>*if you would like to add testosterone, it must be written in custom box below*</i>	0.2%/0.05%	Insert 1 gram intravaginally 1-2 times a day as directed.	<input type="checkbox"/> 60 g <input type="checkbox"/> Other:	
<input type="checkbox"/> Scream Cream (Aminophylline/Arginine/Sildenafil) <i>*if you would like to add testosterone 0.5 mg, it must be written in custom box below*</i>	3%/6%/20mg	Apply a pea size amount to clitoris 30 minutes prior to sexual activity	<input type="checkbox"/> 30 g <input type="checkbox"/> Other:	
<input type="checkbox"/> Lidocaine in <input type="checkbox"/> Acid Mantle <input type="checkbox"/> Petrolatum <input type="checkbox"/> Aloe	<input type="checkbox"/> 5% <input type="checkbox"/> 7.5%	Apply 1 pump (1ml) to affected areas 1-2 times a day as directed	<input type="checkbox"/> 60 g <input type="checkbox"/> Other:	
Barrier Cream & Powder				
<input type="checkbox"/> Greer's Goo (Hydrocortisone 1% /Nystatin 0.033mu/ per gm in Zinc Oxide Base)	1% / 0.033mu /gm	Apply 1-2g to affected area 1-2 times a day as directed.	<input type="checkbox"/> 60 g <input type="checkbox"/> 120 g	
<input type="checkbox"/> Sucralfate Powder		Apply a thin layer to affected area as directed	<input type="checkbox"/> 120g	
Custom Formula: (Examples: Diazepam Suppositories 5, 10, 20mg / Testosterone cream 0.5mg, 1.0mg, 1.5mg, 2mg add to a current formula or alone)				
<input type="checkbox"/>				
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"				

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