Five Star PHARMACY

Compounded *Prescription Order Form*

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Allergies: _____ **Phone**: (_____) _____

COMPOUNDED MEDICATION

Progesterone 50mg/gm Topical Gel (Anhydrous Versabase) HRT

Dose: ❒ 10mg ❒ 25mg ❒ 50mg ❒ 100mg ❒ 200mg ❒ other:_____

NOTE: MAXIMUM DAILY DOSE OF TESTOSTERONE IS 200MG.

Container Type: ❒ EMP jar (measured in gm) ❒ Pump (measured in ml)

Qty: (gm or ml depending on container) ❒45 ❒60❒ 90

Refill: _____ (Max 1 refill w/ a 90-day supply**. The dispensed quantity plus refills cannot exceed 6-month supply**)

Directions: Apply 1 pump (= to dose ordered above) topically to skin daily.
***We will call on all control prescriptions to validate legitimacy when faxed in.**

Progesterone 100mg Troche (Natatroche)

Qty: **Refill:**

Directions:

Clomiphene Topical Gel or Lipoderm Activemax (please circle)

Dose: ❒2.5% ❒ 5%❒ other:_____

Qty: _____ **Directions:**_____

Refills: _____

Prescriber Signature: _____ **Today Date:** _____

Prescriber Printed Name: _____ ☐**MD** ☐**DO** ☐**ND** ☐**PA** ☐**NP** ☐**CNM/CN**

State License: _____ **DEA:** _____ **NPI:** _____

Address: _____**City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **E-mail:** _____

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