

Nasal Preparations



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Please Send Patient Demographics
Along With New Prescription Orders,
Including List of Patient Allergies &
Insurance Information/Social Security
#

Patient Name: _____ Date of Birth: _____
Address: _____ Patient Phone: _____

Person Faxing Request: _____
Prescriber Name: _____ Prescriber Phone: _____
Prescriber DEA: _____ NPI: _____ Prescriber Fax: _____

**** This list is not all inclusive. If different doses, medications, or delivery methods are required, please contact the pharmacy with any questions or requests ****

- **Gentamicin Nasal Irrigation (aka Wilson's Solution) 80mg/L**

Directions: Rinse/flush each nostril with 5-10mL every day as directed

(Please circle desired quantity)

Quantity: 250mL - 500mL - 1000mL **Refills:** _____

- **Budesonide Nasal Irrigation 2mg/L**

Directions: Rinse/flush each nostril with 5-10mL every day as directed

(Please circle desired quantity)

Quantity: 250mL - 500mL - 1000mL - 2000mL **Refills:** _____

- **Budesonide Nasal Concentrate 0.6mg/mL**

Quantity: 60mL **Refills:** _____

Directions: Add 1mL of concentrate medication to 90mL of saline nasal rinse in cup, then irrigate sinuses with 45mL in each nostril twice daily as directed

- **Gentamicin 160/Dexamethasone 120/Itraconazole 200mg/L Nasal Suspension (Irrigation)**

Directions: Irrigate each nostril with 20mL, 2-3 times per day as directed

(Please circle desired quantity)

Quantity: 1000mL - 2000mL **Refills:** _____

- **Gentamicin 1% - Dexamethasone 0.5% - Itraconazole 1% NASAL SPRAY**

Quantity: 30mL **Refills:** _____

Directions: Use 2 sprays in each nostril twice daily or as directed

- **Theophylline 20mcg/0.1mL Nasal Spray**

Quantity: 15mL **Refills:** _____

Directions: Use 1 spray in each nostril twice daily as directed

- **Tranexamic Acid 10% Nasal Spray**

Quantity: 15mL **Refills:** _____

Directions: Use 1-2 sprays per nostril, 2-3 times per day as needed for nosebleeds. May continue for 2-3 days following nosebleeds if needed.

- **Ketamine 100mg/mL (10mg/spray) Nasal Spray** **** please write in desired sprays below based on required dosage ****

Directions: Use _____ sprays in one nostril twice per week at bedtime as directed by physician

(Please circle desired quantity)

Quantity: 15mL - 30mL - 45mL - 60mL **Refills:** _____

Prescriber Signature: _____ **Date:** _____