

Common Dermatology Compounds



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

Patient Name: _____

Address: _____

Prescriber Name: _____

Prescriber DEA: _____ NPI: _____

Date of Birth: _____

Patient Phone: _____

Person Faxing Request: _____

Prescriber Phone: _____

Prescriber Fax: _____

**** ANY INGREDIENTS OR STRENGTHS ON THE FORM MAY BE CHANGED OR DELETED AT PRESCRIBERS DISCRETION ** THIS LIST IS NOT ALL-INCLUSIVE, PLEASE CALL WITH ANY QUESTIONS OR REQUESTS ** PLEASE CHECK THE DESIRED PRESCRIPTION ORDER, MARK THE NUMBER OF REFILLS, SIGN & DATE BELOW ****

**** Melasma/Bleaching Agents**

(Standard cream is delivered in a scar cream base that is anhydrous in nature, and is stable at room temperature for up to 180 days from compound date – the base can be changed to an HRT cream base that is water based upon request, but it will require refrigeration and limits the compound to a 30 day beyond-use-date.)

_____ **Tretinoin 0.025/Hydrocortisone 2.5/Hydroquinone 6% Topical Cream** **#30 gm - Refills** _____

Sig: Apply thin film to affected area(s) topically, once daily at bedtime as tolerated

_____ **Tretinoin 0.05/Fluocinolone 0.01/Hydroquinone 6% Topical Cream** **#30 gm - Refills** _____

Sig: Apply thin film to affected area(s) topically, once daily at bedtime as tolerated

**** Psoriasis/Eczema/Atopic Dermatitis**

(For broad/widespread conditions, we recommend oral Low-Dose Naltrexone as well, see LDN Rx Form)

_____ **Naltrexone 1%/Ketotifen 0.05% Topical Gel** **#30gm - #60gm - #90gm - #120gm -- Refills** _____

Sig: Apply to the affected area(s) 1-2 times per day as directed

_____ **Naltrexone 1%/Ketotifen 0.05% Topical Cream** **#30gm - #60gm - #90gm - #120gm -- Refills** _____

Sig: Apply to the affected area(s) 1-2 times per day as directed

**** Skin Growths/Skin Cancer Treatments**

_____ **Calcipotriene/Fluorouracil 0.0025%/2.5% Cream** **#15gm - #30gm - #60gm - Refills** _____

Sig: Apply to affected area(s) twice daily for 4 days, hold doses if moderate to severe irritation occurs

_____ **Fluorouracil Cream (Please Circle Desired Strength)** **1% 2% 3% 4% 4.5%** **#40 gm - Refills** _____

Sig: Apply to affected area(s) once to twice daily for _____ weeks, hold doses if moderate irritation occurs

**** Topical Antifungal (Nail/Skin Solutions)**

_____ **Ketoconazole 2/DMSO 40/Tea Tree Oil 5% Topical Solution** **#60 ml - Refills** _____

Sig: Apply to affected area(s) twice daily for eight weeks, or as directed

_____ **Fluconazole 1% in DMSO** **#60 ml - Refills** _____

Sig: Apply 1 to 2 drops to affected area(s) of nail(s) after thorough cleaning as directed

**** Hair Loss Foam**

_____ **Minoxidil 10/Finasteride 0.1% (Please circle amount based on desired dosing per day)** **#50 ml (once daily) or #100ml (twice daily)**

Refills _____

Sig: Apply 2 to 4 pumps to dry scalp **once** or **twice** daily and massage in well. Wash hands and allow hair to dry before styling or lying down. Max of 8 pumps per day.

**** Wrinkle Relief & Toning Cream**

_____ **Estriol 0.05%** **(please circle desired quantity)** **#30 gm -- #60gm -- #90gm - Refills** _____

Sig: Apply small amount to desired area(s) every morning and evening as directed

**** Scar Treatment (Starter Formula & Maintenance/Extended Use Formula)**

_____ **Aloe 0.2/Naltrexone 0.2/Nifedipine 0.2/Pentoxifylline 2% Scar Gel (Starter, use x 4 weeks)** **#30 gm - Refills** **0**

Sig: Apply thin film to affected area(s) twice daily x 2 weeks, then decrease to once daily x 2weeks. After 4 weeks, start maintenance dose until desired fading achieved.

_____ **Aloe 0.2/Nifedipine 0.2/Pentoxifylline 2% Scar Gel** **#30 gm - Refills** _____

Sig: Apply thin film to affected area(s) once daily as directed until desired fading achieved.

Prescriber Signature: _____ **Date:** _____