YOUR HEALTH PHARMACY

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ANTI-INFECTIVE – BASSA-GEL™

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____
Allergies: □ NKDA (no known drug allergies) □ Aspirin/ NSAID's □ Cyclobenzaprine □ Lidocaine / Local Anesthetic □ Tramadol □ Opioid
□ Gabapentin □ Penicillin □ Amitriptyline □ Other: _____

ANTI-INFECTIVE GEL DELIVERY

1. ____ CMPD Tobramycin 150mg-Clindamycin 100mg-Mupirocin 25mg-Itraconazole 25mg Cap #120 – Mix 2 caps with BASSA-GEL™, apply to affected areas twice daily
   a. If checked, pharmacy is authorized to dispense the below in lieu of the medication listed in #1 above if needed for any reason or if desired by patient
      i. ____ CMPD Tobramycin 150mg Cap #120 – Mix 2 caps with BASSA-GEL™, apply to affected areas twice daily AND DISPENSE CMPD Clindamycin 150mg-Mupirocin 20mg-Itraconazole 50mg Cap #60 – Mix 1 cap with BASSA-GEL™, apply to affected areas twice daily
      ii. ____ Colistimethate 150mg Vial #120 – Mix 2 vials with BASSA-GEL™, apply to affected areas twice daily AND DISPENSE CMPD Clindamycin 150mg-Mupirocin 20mg-Itraconazole 50mg Cap #60 – Mix 1 cap with BASSA-GEL™, apply to affected areas twice daily
      iii. ____ Nitrofurantoin 25mg Cap #180 – Mix 3 caps with BASSA-GEL™, apply to affected areas twice daily AND DISPENSE CMPD Clindamycin 150mg-Mupirocin 20mg-Itraconazole 50mg Cap #60 – Mix 1 cap with BASSA-GEL™, apply to affected areas twice daily
      iv. ____ CMPD Gentamicin 80mg-Clindamycin 100mg-Mupirocin 20mg Cap #60 – Mix 1 cap with BASSA-GEL™, apply to affected areas twice daily AND DISPENSE CMPD Itraconazole 50mg Cap #60 – Mix 1 cap with BASSA-GEL™, apply to affected areas twice daily
2. ____ OTHER _____

ADDITIONAL MEDICATIONS

If CHECKED, also dispense the following with same dosing frequency indicated above – 1 cap used per treatment

____ CMPD Urea 500mg Cap #60
____ CMPD Urea 500mg-Mometasone 1mg Cap #60
____ CMPD Naltrexone 1.5mg Cap #60
____ CMPD Azelastine 500mcg-Mometasone 1mg Cap #60

Refills: (Number of refills indicated here refers to all medications prescribed above)

____ 1 Year ____ 5 ____ 3 ____ 1 ____ Zero

Physician Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
DEA: _____ NPI: _____

_____ Physician's Signature

_____ Date

FDA does not review any compounded medication for safety/efficacy. CMPD refers to a compounded med.