PAIN MANAGEMENT COMPOUND PRESCRIPTION FORM

PATIENT INFORMATION	PRESCRIBER INFORMATION	
Patient Name:	Prescriber Name:	Today's Date:
Date of Birth:	DEA: NPI:	Need By Date:
SSN:	Address:	**Ship To:**
Address:	City, State, ZIP Code:	☐ Patient
City, State, ZIP Code:	Phone: Fax:	☐ ____________
Phone:	Contact Person:	

PRESCRIPTION INSURANCE INFORMATION	PATIENT BILLING INFORMATION
Insurance Plan Type: Rx BIN:	Credit Card: Visa, Mastercard, American Express, Other
Processor Control No. or PCN (if available):	Credit Card Number:
Identification Number:	CCV (last 3-digits):
Rx Group:	Expiration Date (mm/yy):

PRESCRIPTION INFORMATION

Pain Management

MEDICATION **STRENGTH**

☐ **Ketoprofen _____ % , Cream**

Directions

☐ Apply a thin layer to affected area(s) 2 to 3 times a day.
☐ ____.

Qty
☐ 60 gm
☐ 120 gm
☐ ______ gm

REFILLS
1 2 3 4 5 ____

☐ **Ketoprofen _____ %** ☐ **Gabapentin _____ %** ☐ **Lidocaine _____ %, Cream**

Directions

☐ Apply a thin layer to affected area(s) 2 to 3 times a day.
☐ ____.

Qty
☐ 60 gm
☐ 120 gm
☐ ______ gm

REFILLS
1 2 3 4 5 ____

Custom Compound

MEDICATION **STRENGTH**

☐ **Ketoprofen _____ %** ☐ **Gabapentin _____ %** ☐ **Lidocaine _____ %** ☐ **Ibuprofen _____ %** ☐ **Cyclobenzaprine _____ %**

☐ **Menthol _____ %** ☐ **Capsasin _____ %** ☐ **Camphor _____ % , Cream**

Directions

☐ Apply a thin layer to affected area(s) 2 to 3 times a day.
☐ ____.

Qty
☐ 60 gm
☐ 120 gm
☐ ______ gm

REFILLS
1 2 3 4 5 ____

☐ ____

Directions

☐ Apply a thin layer to affected area(s) 2 to 3 times a day.
☐ ____.

Qty
☐ 60 gm
☐ 120 gm
☐ ______ gm

REFILLS
1 2 3 4 5 ____

CURRENT PHARMACY INFORMATION *to be contacted if we have any issues when billing insurance

Pharmacy Name:

Pharmacy Phone Number:

Pharmacy Fax Number:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Newport Lido Pharmacy to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

☐ **Do Not Substitute**

Prescriber Signature: ____________________________ **Date:** ______________

Newport Lido Pharmacy
351 Hospital Road, Newport Beach, CA 92663

Phone: 949-764-6580
Fax: 949-764-6581

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