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www.towntotalcompound.com

Dermatology Formula Reference Form

Patient Name _____ Date of Birth _____ Sex _____

Patient Address _____ City _____ State _____ Zip _____
No P.O. Box- Street Address Only

Phone Number _____ Alternate Phone _____ Email _____

Allergies _____ Scar Type Or Description _____

Acne (Mild To Moderate)

☐ AZELAIC ACID 20% / NIACINAMIDE 5% CREAM
30GM – APPLY SPARINGLY TO THE AFFECTED AREA 1-2 TIMES DAILY AS TOLERATED

☐ CLINDAMYCIN 1% / BENZOYL PEROXIDE 5% / NIACINAMIDE 4% IN CLARIFYING CREAM
30GM – APPLY TO AFFECTED AREA 1-2 TIMES DAILY TO CLEAN, DRY SKIN

☐ CLINDAMYCIN 1% / TRETINOIN 0.025% IN CLARIFYING CREAM
30GM - APPLY SPARINGLY TO THE AFFECTED AREA AT BEDTIME. WEAR SUNBLOCK DURING THE DAY

Anti-Aging (Menopausel Skin /Dermal Atrophy)

☐ E3 (ESTRIOL) 0.2% IN PRACASIL CREAM
30GM – APPLY SPARINGLY TO FACE AND NECK ONCE DAILY

☐ HYDROQUINONE 4% / TRETINOIN 0.05% / FLUOCINOLONE 0.01% IN PRACASIL CREAM
30GM - APPLY SPARINGLY TO THE AFFECTED AREA AT BEDTIME. WEAR SUNBLOCK DURING THE DAY

Anti-Aging Prevention (Peri-Menopausel Skin/Mild Change)

☐ HYDROQUINONE 4% / TRETINOIN 0.05% / FLUOCINOLONE 0.01% IN PRACASIL CREAM
30GM - APPLY SPARINGLY TO THE AFFECTED AREA AT BEDTIME. WEAR SUNBLOCK DURING THE DAY

Procedure Scar Prevention And Decreased Inflammation

☐ SODIUM HYALURONATE 0.5% / TRETINOIN 0.025% / ALOE VERA 0.5% IN PRACASIL CREAM
30GM – APPLY TO AFFECTED AREA 2 TIMES DAILY

☐ MUPIROCIN 2% / ALOE VERA 0.5% IN PRACASIL CREAM
30GM – APPLY TO AFFECTED AREA 2-3 TIMES DAILY

Other Formulations

ROSCACEA (MILD TO MODERATE)

☐ AZELAIC ACID 20% / NIACINAMIDE 4% IN CLARIFYING CREAM
30GM - APPLY SPARINGLY TO THE AFFECTED AREA 1-2 TIMES DAILY AS TOLERATED

ECZEMA / PSORIASIS

☐ CLOBETASOL PROPIONATE 0.05% / LCD 5% / SALICYLIC ACID 6% IN XEMATOP CREAM
30GM – APPLY TO THE AFFECTED AREA TWICE DAILY FOR UP TO 3 WEEKS. ORDER WITHOUT STERIOD FOR LONG TERM USE

DRY FACIAL SKIN

☐ VITAMIN E 0.5% IN PRACASIL CREAM
30GM – APPLY TO AFFECTED AREA 2-3 TIMES DAILY AS NEEDED

VAGINAL REJUVENATION/VAGINAL ATROPHY
NO CANCER RISKS:

☐ ESTRIOL 2GM/GM VAGINAL CREAM
30GM – INSERT 1 GM VAGINALLY AT BEDTIME FOR 14 DAYS, THEN USE 2-3 TIMES WEEKLY THEREAFTER

SIG: **Refills Requested:** _____
ALTERNATE SIG: _____ **DISPENSE:** **GM** **Other:** _____ **GM**

Additional Medications To Add: _____

Prescriber Verification:

I have reviewed my patient's medical record and determine the medication(s) / supplies ordered are medically necessary. I verify I have examined and diagnosed the patient as indicated above. I will comply with state and federal documentation requirements by retaining a copy of the order in the patient's medical record. The prescription is to be dispensed as written unless otherwise instructed by me. I understand that this form is for reference only and does not constitute a legal New York State Prescription

Prescriber Full Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ ST: _____ Zip: _____

NPI #: _____ DEA: _____ Doctor Specialty: _____

Signature: _____ Date: _____ Office Contact: _____

THIS FORM IS FOR YOUR REFERENCE. WE WILL CONTACT YOU TO CLARIFY WHAT IS TO BE PRESCRIBED*FIRST ORDER:
PLEASE FAX PATIENT DEMOGRAPHICS & INCLUDE CURRENT MEDICATION LIST AND ALLERGY LIST*