Apothecary Options

Prescription Order Form

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Allergies: _____**Phone**: (_____) _____

COMPOUNDED MEDICATION
☐ Fluconazole 2% + Itraconazole 1% + Ibuprofen 2% in DMSO Nail Solution **Quantity:** 30ml **Refills:** _____ **Directions:** Place 1 drop onto center of affected nail(s) twice daily.
☐ Tymol 3% in Ethyl alcohol 70% Nail Solution **Quantity:** 30ml **Refills:** _____ **Directions:** Place 1 drop onto center of affected nail(s) twice daily.
☐ Tymol 4% in Ethyl alcohol 95% Nail Solution **Quantity:** 30ml **Refills:** _____ **Directions:** Place 1 drop onto center of affected nail(s) twice daily.

Prescriber Signature: _____ **Today Date:** _____

Prescriber Printed Name: _____ **□MD □DO □ND □PA □NP □CNM/CN**

State License: _____ **DEA:** _____ **NPI:** _____

Address: _____**City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **E-mail:** _____

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