Apothecary Options

Prescription Order Form

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

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

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

COMPOUNDED MEDICATION

Compounded Ketotifen Capsules
(Lactose-Free Capsules)

Strength: ☐ 0.5 mg ☐ 1 mg ☐ Other: _____mg

Quantity: ☐ 100 ☐other_____ **Refills:** _____

Directions: ☐ Take 1 capsule orally daily.

☐ Other: _____

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:** _____

3006 Esplanade, Suite I, Chico, CA 95973. Phone: 530-345-RxRx (7979) Fax: 530-345-9797
www.apothecaryoptions.com * info@apothecaryoptions.com * **Find us on Facebook**