Compounded Topical Diclofenac Form

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

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

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

☐ **Diclofenac 3% in Versapro Gel**

Sig: Apply sparingly to affected area of lips and surrounding skin around the mouth twice daily for 8 weeks then stop.

Qty: 50gm Refill _____

☐ **Diclofenac 3% in Aquaphor Ointment**

Sig: Apply sparingly to affected area of lips and surrounding skin around the mouth twice daily for 8 weeks then stop.

Qty: 50gm Refill _____

☐ **Diclofenac 3% in Cetaphil Lotion**

Sig: Apply sparingly to affected area of lips and surrounding skin around the mouth twice daily for 8 weeks then stop.

Qty: 50ml Refill _____

☐ **Diclofenac 3% in Versapro Cream**

Sig: Apply sparingly to affected area of lips and surrounding skin around the mouth twice daily for 8 weeks then stop.

Qty: 50gm Refill _____

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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