Prescription Order Form

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

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

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

COMPOUNDED NASAL SPRAYS

All Nasal Sprays have a 30-day Beyond-Use-Date

Antifungal:

☐ Itraconazole 1% + Xylitol 5% + EDTA 0.5%
☐ Itraconazole 0.5% + Xylitol 5% + EDTA 0.5%
☐ Amphotericin B 0.2% + EDTA 0.5%

Antibiotic:

☐ Mupirocin 0.1% + EDTA 1%
☐ Mupirocin 0.3% + EDTA 1%
☐ Mupirocin 0.2% + Gentamicin 0.5% + EDTA 1%

Antifungal/Antibiotic:

☐ Itraconazole 1% + Mupirocin 0.2% + Xylitol 5% + EDTA 0.5%
☐ Amphotericin B 0.2% + Gentamicin 0.5% + EDTA 0.1%

Anesthetic/Pain:

☐ Lidocaine ☐2% ☐4%
☐ Ketamine 10%

Other:

☐ EDTA ☐0.1% ☐ 0.5% ☐ 1%
☐_____

May add or substitute to above formulas *(if substituting then cross out any ingredients above that you are substituting for):*

☐ Gentamicin 0.5%	☐ Amphotericin B 0.2%	☐ Cromolyn 5%	☐ Ketoconazole 2%
☐ Aloe 0.1%	☐ Budesonide 0.025%	☐ EDTA 0.5%	☐ Mupirocin 0.2%
☐ Itraconazole 0.5%	☐ Ketotifen 0.05%	☐ Xylitol 5%	☐ Lidocaine 2%

Quantity (0.1ml/Spray): ☐ 12ml ☐ 24ml **Refills:** _____

Directions: Instill ☐1 ☐ 2 ☐ 1-2 sprays → into EACH nostril ☐ once daily ☐ twice daily.

Alternate/Additional Directions:_____

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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