



Prescription Order Form

Patient Name: _____ Date of Birth: _____

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

Allergies: _____ Phone: (_____) _____

CUSTOM COMPOUNDED MEDICATION

Check all that apply:

- √ Provider requesting the formula to be specifically compounded in Vanishing Cream base
- √ All formulas contain **ascorbic acid 1%** and **vitamin E acetate 1.4%**

Hydroquinone ☐ 2% ☐ 4% ☐ 6% ☐ 8% ☐ 10%

Kojic Acid ☐ 2% ☐ 4% ☐ 6%

Retinoic Acid ☐ 0.025% ☐ 0.05% ☐ 0.1%

Estriol (E3) ☐ 0.3% OR Estradiol (E2) ☐ 0.01%

Desonide 0.05% ☐ OR Hydrocortisone ☐ 0.5% ☐ 1%

Quantity: ☐ 30gm ☐ 60gm

Refills: _____

Directions: Apply sparingly to affected areas of skin at bedtime. Apply sunscreen to treated areas during the daytime.

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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