BHRT *Prescription Order Form*

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

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

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

COMPOUNDED MEDICATION

√ Provider requesting the formula to be compounded in HRT cream Base

❑ **Bi-Est (E2/E3):** ☐ **20/80%** ☐ **50/50%** _____ **mg/DOSE (**Range: 0.2mg – 1mg per DAY)

❑ **Estradiol (E2):** _____ **mg/DOSE** (Range: 0.025–0.5mg per DAY)(Usual 0.05mg/DOSE)

❑ **Estriol (E3):** _____ **mg/DOSE** (Range: 0.25-2mg per DAY)

❑ **Progesterone:** _____ **mg/DOSE** (Range:10-50 mg per dose)

❑ **Testosterone:** _____ **mg/DOSE** (Range:0.25–2mg per day *(max 90-day supply Plus 1 refill (total 180 day supply allowed by law))*

❑ **DHEA:** _____ **mg/DOSE** (Range: 0.5–5mg per day)

❑ **Check this box if you want us to combine all the hormones into one formula. Some limitations apply.**

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1. **Directions:** _____

(Application per dose usually equals 0.5-1gm depending on drug concentration and application site, we usually make the concentration double the dose to achieve the amount applied)

2. ***Form:*** Cream

3. ***Route*:** ☐ topically ☐ vaginally (w/finger) ☐ Intravaginally (w/applicator) ☐_____

4. ***Frequency:*** ☐daily ☐three times weekly ☐Other: _____

5. ***Container:*** ☐EMP jar ☐Pump (note:1 pump = 0.5ml) ☐Clicker (note:20 clicks = 1ml)

Quantity: ❑ 30gm ❑ 45gm ❑ 60gm ❑ Other:_____ **Refills:**_____

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**