WHCP
Woodland Hills Compounding Pharmacy

Rx

# ENT COMPOUND ORDER FORM

Phone: (855) 876-3060 | Fax: (866)893-9320

## PATIENT INFORMATION

PATIENT NAME (PRINT) _____ DOB _____

ALLERGIES _____ DIAGNOSIS CODE _____

PATIENT ADDRESS _____

CITY STATE ZIP _____

HOME PHONE _____ CELL PHONE _____

## INSURANCE INFORMATION

INSURANCE NAME _____ MEMBER ID _____

BIN _____ GROUP #_____ PCN # _____ HELP DESK PHONE#_____

| PRODUCT | SIZE | REFILLS |
|---|---|---|
| **Nasal Sprays** | | |
| ☐ BEG Nasal Spray<br>*Bactroban 0.2%, EDTA 1%, Gentamicin 0.5%* | 50mL | _____ |
| ☐ Itraconazole 1% Nasal Spray | 50mL | _____ |
| ☐ Amphotericin B 0.25% Nasal Spray | 50mL | _____ |
| ☐ Bactroban (Mupirocin) 0.2% Nasal Spray<br>Sig: Use 1 spray in each nostril twice a day | 50mL | _____ |

| CSF Otic Powder | SIZE | REFILLS |
|---|---|---|
| ☐ Formula #1<br>*Accordian insufflator containing:*<br>*Chloramphenicol 1500mg, Sulfamethoxazole 1500mg, Amphotericin 150mg, Hydrocortisone 30mg*<br>Sig: Give _____ puffs _____ times a day in _____ ear(s). | 3gm | _____ |
| ☐ Formula #2<br>*Accordian insufflator containing:*<br>*Chloramphenicol 1000mg, Sulfamethoxazole 1000mg, Amphotericin 500mg, Hydrocortisone 90mg*<br>Sig: Give _____ puffs _____ times a day in _____ ear(s). | 3gm | _____ |

| Tetracaine Solutions | Additional Ingredients | SIZE | REFILLS |
|---|---|---|---|
| ☐ Tetracaine 2% | ☐ Add Oxymetazoline 0.05% | 8oz | _____ |
| ☐ Tetracaine 4% | ☐ Add Phenylephrine 1% | 8oz | _____ |
| ☐ Tetracaine 6% | | 8oz | _____ |

## Physician Verification

I have reviewed my patient's medical record and determined the medication(s) / supplies ordered are medically necessary. I verify I have examined and diagnosed the patient as indicated above. I will comply with state and federal documentation requirements by retaining a copy of this prescription in the patient's medical record. The prescription is to be dispensed as written unless otherwise instructed by me.

Signature: _____ Date: _____

Physician: _____ NPI #: _____

Address: _____ City: _____ ST: ____ Zip: _____

Phone: _____ Fax: _____

**FAX FORM TO: (866) 893-9320**

**IMPORTANT: Please fax insurance card. Your patient will be called promptly.**

Revision Date: 09/23/2016