Woodland Hills Compounding Pharmacy

BHRT 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			REFILLS
☐ Bi-Est (80/20) Crm ☐ Bi-Est (50/50) Crm	☐ 2mg/ml ☐ 6mg/ml ☐ 4mg/ml ☐ 8mg/ml	☐ Apply 4 clicks (1ml) once a day	Refill:_____
☐ Estradiol Crm	☐ 1mg/ml ☐ 3mg/ml ☐ 2mg/ml ☐ 4mg/ml	☐ Apply 4 clicks (1ml) once a day	Refill:_____
☐ Progesterone Crm	☐ 100mg/ml ☐ 200mg/ml	☐ Apply 4 clicks (1ml) once a day	Refill:_____
☐ Progesterone Caps	☐ 100mg ☐ 200mg	☐ Take 1 capsule PO at bedtime	Refill:_____
☐ Progesterone SR Caps	☐ 100mg ☐ 200mg	☐ Take 1 capsule PO at bedtime	Refill:_____
☐ Testosterone Crm	☐ 1mg/ml ☐ 3mg/ml ☐ 2mg/ml ☐ 4mg/ml	☐ Apply 4 clicks (1ml) once a day	Refill:_____
☐ Bi-Est 2.5mg, Progesterone 100 mg/ml Crm		☐ Apply 4 clicks (1ml) once a day	Refill:_____
☐ Bi-Est 2.5mg, Progesterone 100mg/ml, Testosterone 1mg/ml Crm		☐ Apply 4 clicks (1ml) once a day	Refill:_____
☐ Estriol Vaginal Cream	☐ 0.1% ☐ 0.2% ☐ 0.05% ☐ 0.5%	☐ Take 1 capsule po qHS ☐ Take 1 capsule po B	Refill:_____
☐ Liothyronine (T3) SR Capsule	☐ 5mcg ☐ 15mcg ☐ 7.5mcg ☐ 20mcg ☐ 10mcg ☐ 30mcg	☐ Take 1 capsule po Qam	Refill:_____
☐ Oxytocin 50 Unit Tablets	#30	☐ Take 1 tablet under tongue at bedtime ☐ _____	Refill:_____

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: 09/26/2016