# Woodland Hills Compounding Pharmacy

## PAIN COMPOUND ORDER FORM

Rx

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 |
|---|---|---|
| ☐ Dexamethasone 0.4% LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Gabapentin 6% / ketoprofen 10% / lidocaine 10% LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Indomethacin 20% / lidocaine 10% LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Ketoprofen 10% / lidocaine 5% LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Ketoprofen 20% / lidocaine 10% LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Lidocaine 5% LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Lidocaine 10% LDS* | ☐ 60gm ☐ 120gm | _____ |
| → Sig: Apply a thin layer to affected area twice daily,dosed 6 hours apart,then withhold for 12 hours. | | |
| ☐ Cyclobenzaprine HCL 2% / Ketoprofen 20% LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Diclofenac sodium 10% LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Diclofenac sodium 20% LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Gabapentin 6% LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Gabapentin 10% LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Indomethacin 10% LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Indomethacin 20% LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Ketoprofen 10% LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Ketoprofen 20% LDS* | ☐ 60gm ☐ 120gm | _____ |
| → Sig: Apply a thin layer to affected area twice daily as directed by physician. | | |
| ☐ Cyclobenzaprine 2% / Ketoprofen 20% / Capsaicin 0.0375% / Menthol 10% / Camphor LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Cyclobenzaprine 2% / Ketoprofen 20% / Capsaicin 0.05% / Menthol 10% / Camphor LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Cyclobenzaprine 2% / Ketoprofen 20% / Capsaicin 0.0625% / Menthol 10% / Camphor LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Ketoprofen 10% / Capsaicin 0.0375% / Menthol 10% / Camphor LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Ketoprofen 20% / Capsaicin 0.0375% / Menthol 10% / Camphor LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Capsaicin 0.0375% / Menthol 10% / Camphor LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Capsaicin 0.05% / Menthol 10% / Camphor LDS* | ☐ 60gm ☐ 120gm | _____ |
| ☐ Capsaicin 0.0625% / Menthol 10% / Camphor LDS* | ☐ 60gm ☐ 120gm | _____ |
| → Sig: Apply thin layer to affected area 15 minutes before exercise and as needed. | | |

*Liposomal Delivery System

### 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: 09/06/2016