WHCP
Woodland Hills Compounding Pharmacy

Rx

COLORECTAL 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	QTY	REFILLS
Nifedipine Ointment		
☐ Nifedipine 0.2%Ointment	☐ 30gm ☐ 60gm	_____
☐ Nifedipine 0.3%Ointment	☐ 30gm ☐ 60gm	_____
☐ Nifedipine 0.2%, Lidocaine 2% Ointment	☐ 30gm ☐ 60gm	_____
☐ Nifedipine 0.3%, Lidocaine 5% Ointment	☐ 30gm ☐ 60gm	_____
	Directions: Apply rectally three times a day	
Diltiazem Ointment		
☐ Diltiazem 2% Ointment	☐ 30gm ☐ 60gm	_____
☐ Diltiazem 2%, Lidocaine 3% Ointment	☐ 30gm ☐ 60gm	_____
☐ Diltiazem 2%, Lidocaine 5% Ointment	☐ 30gm ☐ 60gm	_____
	Directions: Apply rectally three times a day	
Nitroglycerin Ointment		
☐ Nitroglycerin 0.125% Ointment	☐ 30gm ☐ 60gm	_____
☐ Nitroglycerin 0.2% Ointment	☐ 30gm ☐ 60gm	_____
☐ Nitroglycerin 0.4% Ointment	☐ 30gm ☐ 60gm	_____
	Directions: Apply rectally three times a day	

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