WHCP
Woodland Hills Compounding Pharmacy

COMPOUND HRT ORDER FORM

20631 Ventura Blvd Ste 305 Woodland Hills, CA 91364
Phone: 855-876-3060 Fax: 866-893-9320

Rx

PATIENT INFORMATION

PATIENT _____

DOB ___/___/___ AGE _____

SEX MALE ☐ FEMALE ☐ HOME _____

WORK _____ CELL _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MEDICAL INSURANCE INFORMATION

BIN # _____ PCN # _____

ID # _____ GROUP # _____

INS FAX # _____

INS TEL # _____

MEDICATION ALLERGIES: _____

Continuous HRT Creams

*All HRT creams are dispensed in Topi-Click Dispenser (1 click=0.25ml) in 30 days supply unless otherwise indicated

☐ 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:_____

Combination Creams

☐ Bi-Est 2.5mg, Progesterone 100 mg/ml Crm	☐ Apply 4 clicks (1ml) once a day	
☐ Bi-Est 2.5mg, Progesterone 100mg/ml, Testosterone 1mg/ml Crm	☐ Apply 4 clicks (1ml) once a day	Refill:_____

Cyclical HRT Creams

*Includes specialized click dispensers (HR Ticker) and dosing schedule (1 click= 0.05ml)

☐ Estriadiol 1mg/0.1ml Crm	☐ Use as directed (days 1-28 of the month)	Refill:_____
☐ Progesterone 20mg/0.1ml Crm	☐ Use as directed (days 14-28 of the month)	Refill:_____
☐ Other Compound _____	Sig _____	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: 08/04/2016