WHCP
Woodland Hills Compounding Pharmacy

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MISC 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
❑ Low Dose Naltrexone (LDN) Capsules Directions: Take 1 capsule by mouth at bedtime	❑ 1.5mg #30 #60 #90 ❑ 3mg #30 #60 #90 ❑ 4.5mg #30 #60 #90	_____ _____ _____
❑ Tranilast Capsules Directions: Take 1 capsule by mouth 3 times a day	❑ 200mg #30 #60 #90 ❑ 300mg #30 #60 #90	_____ _____
❑ Tranilast Cream Directions: Apply to affected area(s) twice a day	❑ 10% 30gm ❑ 15% 30gm	_____ _____
❑ 4-Aminopyridine Capsules Directions: Take 1 capsule by month twice a day	❑ 5mg #30 #60 #90 ❑ 10mg #30 #60 #90 ❑ 15 mg #30 #60 #90 ❑ 5mg SR #30 #60 #90	_____ _____ _____ _____
❑ Erythromycin Capsules (SIBO) Directions: Take 1 capsule by mouth at bedtime	❑ 100mg #30 #60 #90	_____ _____
❑ BEG Nasal Spray: Bactroban (Mupirocin) 0.2%, Edetate Disodium (EDTA) 1%, Gentamicin 0.5% Directions: Use 1 spray in each nostril twice a day	50mL	_____
❑ Glutathione 10% Nasal Spray Directions: Use 1 spray in each nostril 3 times a day	50mL	_____
❑ Sildenafil Troche Directions: Dissolve 1 troche under tongue 1/2 hour before activity	❑ 50mg #30 ❑ 100mg #30	_____ _____
❑ Oxytocin 50 unit Tablets Directions: Dissolve 1 tablet under tongue at bedtime	#30	_____

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