WHCP
Woodland Hills Compounding Pharmacy

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LUPUS 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
Atabrine (Quinacrine)			
☐ Quinacrine 50mg Capsules	☐Sig: Take 1 capsule by mouth every day	☐ #30 ☐ #60 ☐ #90	_____
☐ Quinacrine 100mg Capsules	☐Sig: Take 1 capsule by mouth twice a day	☐ #30 ☐ #60 ☐ #90	_____
Aralen (Chloroquine)			
☐ Chloroquine 100mg Capsules	☐Sig: Take 1 capsule by mouth every day	☐ #30 ☐ #60 ☐ #90	_____
☐ Chloroquine 250mg Capsules	☐Sig: Take 1 capsule by mouth twice a day	☐ #30 ☐ #60 ☐ #90	_____
☐ Chloroquine 500mg Capsules		☐ #30 ☐ #60 ☐ #90	_____
Plaquenil (Hydroxychloroquine)			
☐ Hydroxychloroquine 200mg Capsules	☐Sig: Take 1 capsule by mouth every day	☐ #30 ☐ #60 ☐ #90	_____
☐ Hydroxychloroquine 300mg Capsules	☐Sig: Take 1 capsule by mouth twice a day	☐ #30 ☐ #60 ☐ #90	_____
☐ Hydroxychloroquine 400mg Capsules		☐ #30 ☐ #60 ☐ #90	_____
Combination Products			
☐ Quinacrine 100mg, Chloroquine 250mg Capsules	☐Sig: Take 1 capsule by mouth every day	☐ #30 ☐ #60 ☐ #90	_____
☐ Quinacrine 100mg, Chloroquine 250mg, Hydroxychloroquine 200mg Capsules	☐Sig: Take 1 capsule by mouth twice a day	☐ #30 ☐ #60 ☐ #90	_____
Other Compounds:			
_____		_____	_____

Directions:

_____

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