BHRT Compounding

Patient Information

Patient Name:		Date of Birth:	☐ Male ☐ Female
Address:	City:	State:	Zip:
Phone:	Email:	Language:	
Allergies:			☐ NKDA

☐ Pick up / Ship to: ☐ Patient ☐ Office ☐ Alternative Address:

** By providing your mobile phone number you agree to receive a text message from with instructions and steps to provide payment for your medication. This is not advertising.

Insurance: Please fax copy of insurance card (front and back)

Prescriber Information

Practice Name:		Office Contact:	
Prescriber:		NPI:	DEA:
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information

Diagnosis:	ICD-10:

Compounded Prescription Information

Compound		Dose	Directions	Quantity	Refills
☐ Biest (80% Estriol, 20% Estradiol) ☐ Biest (50% Estriol, 50% Estradiol) ☐ Estradiol	☐ Cream	______ mg/mL			
	☐ Capsules ☐ Troche	______ mg			
☐ Progesterone	☐ Cream	______ mg/mL			
	☐ Capsules ☐ Troche	______ mg			
☐ Estriol Vaginal Suppositories ☐ DHEA 6.5mg		☐ 3 mg ☐ 5 mg	Insert 1 suppository intravaginally QD HS	☐ 30 units ☐ Other:	
☐ Oxytocin Sublingual Tabs		☐ 5 units	1-2 tabs sublingual every ☐ AM ☐ PM	☐ 30 tabs ☐ 60 tabs ☐ Other:	
☐ Hormone-Free Vaginal Moisturizer ☐ DHEA 6.5mg (Hyaluronic Acid/Poloxamer/Vitamin E Gel)		☐ 0.05%/30%	Insert 1 gram intravaginally HS	☐ 30 g ☐ Other:	
☐ Estriol/Hyaluronic Acid in Poloxamer 30% Gel		☐ 1 mg/0.05%	Insert 1 gram intravaginally QD	☐ 30g ☐ Other:	
☐ Scream Cream (Aminophylline/Arginine/Sildenafil) **if you would like to add testosterone 0.5mg, it must be written in custom box below**		☐ 3%/6%/20 mg	Apply pea size amount to clitoris 30 minutes prior to sexual activity	☐ 30g ☐ Other:	
☐ Thyroid (Porcine Source) MR (Modified Release) Caps		☐ ______ mg			
☐ Thyroid (Synthetic Source)	Levothyroxine (T4) Liothyronine (T3)	☐ T4 ______ mcg ☐ T3 ______ mcg			

Custom Formula: *In addition the box can be used for (adding **testosterone** to any of the above formulas, **Diazepam** or **Lorazepam** Vaginal Suppositories Extra)

☐				

Prescriber Signature and Date (Please sign and date below)

Prescriber Signature ______________________________ Date

Check here to authorize the receiving pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber's behalf. "I certify that the above therapy is medically necessary, and the above information is accurate to the best of my knowledge"

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