



Patient Information			
Patient Name:		Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		City:	State: Zip:
Phone:	Email:		Language:
Allergies:			<input type="checkbox"/> NKDA
<input type="checkbox"/> Pick Up / Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Office <input type="checkbox"/> Alternative Address:			

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	Strength	Directions	QTY	Refills	Compound	Strength	Directions	QTY	Refills
Nausea and Vomiting Topicals					Dry Mouth				
<input type="checkbox"/> Ondansetron	<input type="checkbox"/> 4 mg/0.1 mL <input type="checkbox"/> 8 mg/0.1 mL	Apply 0.1 mL topically to inner forearm q4h prn nv	<input type="checkbox"/> 5 mL <input type="checkbox"/> Other:		<input type="checkbox"/> Pilocarpine	5 mg: <input type="checkbox"/> Lollipop <input type="checkbox"/> Troche	Use sublingually or buccally PO 3-4 times daily prn nv	<input type="checkbox"/> #30 <input type="checkbox"/> Other:	
<input type="checkbox"/> Promethazine	25 mg/mL	Apply 1 mL topically to inner forearm up to qid prn nv	<input type="checkbox"/> 30 mL <input type="checkbox"/> Other:		<input type="checkbox"/> Pilocarpine Oral Spray	10 mg/mL	Use 1-2 sprays PO 3-4 times daily prn nv	<input type="checkbox"/> 30 mL bottle <input type="checkbox"/> Other:	
<input type="checkbox"/> ABHR Topical Gel: Lorazepam, Diphenhydramine, Haloperidol, Metoclopramide	1 mg, 12.5 mg, 2 mg, 20 mg/mL	Apply 1 mL topically q4-6h prn	<input type="checkbox"/> 30 mL <input type="checkbox"/> Other:		Mouth Pain/Oral Sores				
<input type="checkbox"/> ABHR Suppositories: Lorazepam, Diphenhydramine, Haloperidol, Metoclopramide	1 mg, 12.5 mg, 2 mg, 20 mg	Insert 1 suppository pr q4-6h prn nv	<input type="checkbox"/> #30 <input type="checkbox"/> Other:		<input type="checkbox"/> Oral Rinse: Misoprostol, Diphenhydramine, Lidocaine	0.0024%, 0.1%, 2%	Swish and spit 15 mL PO q4-6h prn	<input type="checkbox"/> 480 mL bottle <input type="checkbox"/> Other:	
<input type="checkbox"/> Ondansetron	<input type="checkbox"/> 4 mg <input type="checkbox"/> 8 mg	Insert 1 suppository pr q6-8h prn nv	<input type="checkbox"/> #30 <input type="checkbox"/> Other:		<input type="checkbox"/> Oral Rinse: Misoprostol, Lidocaine	0.0024%, 1%		<input type="checkbox"/> 480 mL bottle <input type="checkbox"/> Other:	
Nausea and Vomiting Sublingual/Buccal					Ketamine 50 mg Lollipop: This item must be written out by the physician below. Example: Ketamine 50 mg lollipop (#30): Use one lollipop sublingually or buccally q4-6h prn mouth pain				
<input type="checkbox"/> Ondansetron Ginger Apple Lollipop	<input type="checkbox"/> 4 mg <input type="checkbox"/> 8 mg	Use 1 lollipop sublingually or buccally q4h prn nv	<input type="checkbox"/> #30 <input type="checkbox"/> Other:		<input type="checkbox"/> Doc's Chemotherapy Mouthwash: Lidocaine HCl, Diphenhydramine HCl, Mylanta, Nystatin <input type="checkbox"/> Add Tetracycline and Hydrocortisone	0.5%, 0.06%, 25%, 25,000 U/mL	Rinse mouth with 15 mL of mouthwash 4 times daily prn	<input type="checkbox"/> 12 oz. <input type="checkbox"/> Other:	

Other Topicals						
<input type="checkbox"/> Radiation Burns/Related Pain Diclofenac 4% / Lidocaine 2% / Misoprostol 0.0024% / Phenytoin 2% / Aloe Vera 0.2%	<input type="checkbox"/> Neuropathic Pain Acyclovir 10% Lidocaine 5% Amitriptyline 2%	<input type="checkbox"/> EGFR Rash Clindamycin 2% / Hydrocortisone 1%	<input type="checkbox"/> Pain 67 Meloxicam 0.18% / Topiramate 1% / Tramadol 0.25% / Lidocaine 2% / Prilocaine 2%	<input type="checkbox"/> Pain 68 Meloxicam 0.18% / Topiramate 1% / Tramadol 0.25% / Pentoxifylline 7.5% / Lidocaine 2% / Prilocaine 2%	<input type="checkbox"/> Radiation Burn Cream "For Pain" Ketoprofen 5% / Lidocaine 2% / Hyaluronic Acid 0.5% / Urea 10% in PracaSil	
Directions: Apply 1 pump (1 pump = 1.5mL) topically to the affected area 3-4 times a day. QTY: <input type="checkbox"/> 150ml pump <input type="checkbox"/> Other:					Directions: Apply 1 pump (1 pump = 1mL) topically to the affected area 3-4 times per day. QTY: <input type="checkbox"/> 30 g <input type="checkbox"/> 60 g <input type="checkbox"/> 90 g	

DEA CONTROL DRUG REQUIREMENTS: DEA regulations require a pharmacy to receive a new valid signed prescription or verbal prescription. DEA has further said that "A PHARMACY MAY NOT PROVIDE A PARTIALLY OR FULLY PRE-POPULATED FORM FOR THE PRESCRIBING PRACTITIONER." Therefore, any formula with **KETAMINE** or **TESTOSTERONE**, MUST WRITE OUT THE COMPLETE FORMULA in order to comply with the DEA. Thank you.

Sig: _____ QTY: _____ Refills: _____

Custom:

Prescriber Signature and Date (Please sign and date below)

Prescriber Signature	Date
"I authorize Curexa™ 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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