COMPOUND ORDER FORM

Valid only if transmitted by facsimile machine

PATIENT INFORMATION

PATIENT NAME: DATE OF BIRTH:

☐ DELIVER TO PATIENT SSN:

ADDRESS: PHONE:

CITY: STATE: ZIP:

ALLERGIES:

☒ **Sodium Chloride 0.9%** Inhalation Solution - QS to amount prescribed

ANTIBIOTIC THERAPY

☐ **Levofloxacin 125mg**

☐ **Mupirocin 5mg**

ANTIBIOTIC/ANTI-INFLAMMATORY THERAPY

☐ **Levofloxacin 125mg, Budesonide 0.5mg**

☐ **Mupirocin 5mg, Budesonide 0.5mg**

ANTIBIOTIC/ANTI-INFLAMMATORY/ANTI-FUNGAL THERAP

☐ **Levofloxacin 125mg, Budesonide 0.5mg, Fluconazole 50mg**

☐ **Mupirocin 5mg, Budesonide 0.5mg, Fluconazole 50mg**

ANTI-INFLAMMATORY

☐ **Budesonide 0.5mg**

ADDITIONAL FORMULA

SIG (CHOOSE ONE)

☐ Mix the contents of one dose with sodium chloride solution ☐ BID OR ☐ TID

☐ 30 Day OR ☐ 45 Day OR ☐ ____ Day

☐ **Other Sig**

Refills 0 1 2 3 4 5 PRN

PRESCRIBER

NAME: **DEA#** **PHONE:**

ADDRESS:

SIGNATURE: **DATE:**

Dispense As Written **May Substitute**

NOBLESVILLE PHARMACY

FAX COMPLETED PRESCRIPTION • PATIENT INSURANCE INFORMATION (IF AVAILABLE) • PATIENT PHONE NUMBER

TO: (317) 900-7458

NOBLESVILLE LOW COST PHARMACY • 758 Westfield Rd • Noblesville, IN 46062 • (317) 231-5252