

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 THERAPY

☐ 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

The information provided herein is for reference only and is not to be relied upon as making any representation as to the efficacy of any particular formulations. The sample formulations described herein result from prescriptions previously ordered by professionals licensed to write prescriptions in their respective discipline. Nothing herein is intended to replace or influence the independent judgment of any licensed professional.



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