

BHRT PRESCRIPTION ORDER FORM

PATIENT INFORMATION

Patient name: _____

DOB: _____

Address: _____

Phone: _____

Allergies: _____

Diagnosis / indication: _____

Reason compounded preparation needed (select one):

☐ Excipient allergy / intolerance ☐ Dose or dosage form not commercially available ☐ Other: _____

PRESCRIBER INFORMATION

Prescriber name: _____

NPI: _____

DEA _____

Address: _____

Phone: _____

Fax: _____

Commonly prescribed compounded preparations | Each checked item is one patient-specific prescription

ESTROGEN AND VAGINAL SUPPORT

BI-EST TRANSDERMAL CREAM *(usual dosage 0.25 to 2 mg/day)*

Ratio:

☐ 50/50 ☐ 80/20

Dose:

☐ 0.5 mg ☐ 1 mg ☐ 1.5 mg ☐ 2 mg ☐ other _____

DIRECTIONS AND DISPENSE

Apply to the selected site: ☐ daily ☐ other _____

Site: _____

Dispense: ☐ 30 day ☐ 60 day ☐ 90 day

Refills: _____

☐ **Estriol 0.05% vaginal cream**

Insert 1 mL vaginally nightly for 3-4 weeks, then twice weekly.

Dispense 30 gm

Refills: _____

☐ **Estriol vaginal tablet triturate 0.5 mg**

Insert 1 tablet nightly for 14 days, then twice weekly.

Disp: ☐ #18 ☐ #8.

Refills: _____

☐ **Zinc sulfate 3 mg/g + hyaluronic acid + vitamins E and A vaginal cream *(non-hormonal option)***

Insert 1 mL vaginally nightly for 14 days, then 2-3 times weekly.

Dispense 30 gm

Refills: _____

PROGESTERONE *(usual oral dosage 25 to 300 mg/day; usual transdermal dosage 20 to 50 mg/day)*

SUSTAINED RELEASE CAPSULES

Select one: ☐ 50 mg ☐ 100 mg ☐ 150 mg ☐ 200 mg

☐ other _____

Take 1 capsule by mouth at bedtime.

Disp: ☐ #30 ☐ #60 ☐ #90 Refills: _____

TRANSDERMAL CREAM

Select one: ☐ 10 mg ☐ 25 mg ☐ 50 mg ☐ other _____

Apply to the selected site: ☐ daily ☐ bid ☐ other _____

Site: _____

Disp: ☐ 30 day ☐ 60 day ☐ 90 day Refills: _____

SCHEDULE: ☐ Regular cycles - bedtime on cycle days 15-25 ☐ Irregular or no cycles - bedtime continuously ☐ Other: _____

TESTOSTERONE *(usual female transdermal dosage 0.25 to 2 mg/day; usual male transdermal gel dosage 10 to 150 mg/day)*

Separate prescription required: compliant e-prescription, manually signed fax, or verbal order, as permitted by law.

Female: VersaBase Cream. Male: VersaBase Gel or Lipoderm Cream.

PHYSICIAN WRITTEN PRESCRIPTION

☐ **Use a physician-written noncontrolled prescription instead of the preselected choices above**

Medication / strength / dosage form: _____

Complete SIG / special instructions: _____ Disp: _____ Refills: _____

TOTAL NUMBER OF PRESCRIPTIONS ORDERED

PRESCRIBER AUTHORIZATION

Prescriber signature: _____

Date: _____