

NEW PRESCRIPTION ORDER FORM

1 Patient Information

Last Name		First Name		MI
Address				Apt. #
City	State	ZIP	Phone Number	
Date of Birth (mm/dd/yyyy)		Sex	☐ M ☐ F	Email

2 Prescriber and Prescription Information

Prescriber's Name		
Phone Number		Fax Number
Street Address		
City	State	ZIP
NPI	DEA	



Commonly Requested Formulas for Patients with Eosinophilic Esophagitis (EOS) or Eosinophilic Colitis

- ☐ Budesonide 1 mg/10 mL to 2 mg/10 mL Oral Suspension
- ☐ Montelukast 1 mg/ml/Ketotifen 0.5 mg/ml/Budesonide 0.5 mg/ml Oral Suspension
- ☐ Montelukast 1 mg/ml/Ketotifen 0.5 mg/ml/Budesonide 0.5 mg/ml/Quercetin 10mg/ml Oral Suspension

Directions:

QTY: _____

Refills: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Other: _____

X _____
Prescriber's Signature Date

3 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

Pharmacy Name

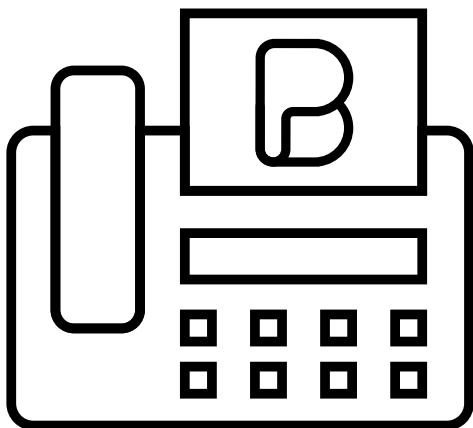
Pharmacy Fax Number

The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10



Your modern compounding pharmacy.™

FAX COVER SHEET



Please fax your order to:

401-284-4506

3844 Post Road, Warwick RI 02886

Phone: 401 - 284 - 4505

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