ILLINOIS COMPOUNDING PHARMACY
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LOW DOSE NALTREXONE ORDER FORM

PATIENT INFORMATION SECTION			PRESCRIBER INFORMATION SECTION		
Patient Name:			Prescriber Name:		
Address:			DEA:	NPI:	
City:	State:	Zip:	City:	State:	Zip:
Phone:	Allergies:		Phone:	Fax:	

LOW DOSE NALTREXONE (LDN) INITIAL DOSE / TITRATION PACK

Titration Pack (Check the appropriate boxes next to dosage and number of days to match desired titration):

☐ Naltrexone 0.5 mg capsules	☐ QHS	☐ BID	☐ x 7 days	☐ x 14 days	☐ x 21 days
☐ Naltrexone 1 mg capsules	☐ QHS	☐ BID	☐ x 7 days	☐ x 14 days	☐ x 21 days
☐ Naltrexone 1.5 mg capsules	☐ QHS	☐ BID	☐ x 7 days	☐ x 14 days	☐ x 21 days
☐ Naltrexone 2 mg capsules	☐ QHS	☐ BID	☐ x 7 days	☐ x 14 days	☐ x 21 days
☐ Naltrexone 2.5 mg capsules	☐ QHS	☐ BID	☐ x 7 days	☐ x 14 days	☐ x 21 days
☐ Naltrexone 3 mg capsules	☐ QHS	☐ BID	☐ x 7 days	☐ x 14 days	☐ x 21 days
☐ Naltrexone 3.5 mg capsules	☐ QHS	☐ BID	☐ x 7 days	☐ x 14 days	☐ x 21 days
☐ Naltrexone 4 mg capsules	☐ QHS	☐ BID	☐ x 7 days	☐ x 14 days	☐ x 21 days
☐ Naltrexone 4.5 mg capsules	☐ QHS	☐ BID	☐ x 7 days	☐ x 14 days	☐ x 21 days
☐ Naltrexone _____ mg capsules	☐ QHS	☐ BID	☐ x 7 days	☐ x 14 days	☐ x 21 days

☐ PRN Refills

☐ Pharmacy titration: Clinical pharmacist to provide a dosage recommendation to the prescriber after review of patient case.

☐ Take 1 capsule by mouth nightly at bedtime, increase by 0.5 mg every _____ week(s) until cliffhanger effect.

☐ May challenge dosing after consulting with Clinical Pharmacist or Provider.

LOW DOSE NALTREXONE (LDN) MAINTENANCE DOSE

☐ Naltrexone Capsules ☐ 1.5 mg ☐ 2 mg ☐ 2.5 mg ☐ 3 mg ☐ 3.5 mg ☐ 4 mg ☐ 4.5 mg ☐ _____ mg

Sig: Take 1 capsule by mouth ☐ QHS ☐ BID **Day Supply:** ☐ 30 days ☐ 60 days ☐ 90 days

OTHER

☐ Other Medication: _____

Sig: _____

QUANTITY

☐ 30 days ☐ 60 days ☐ 90 days

If a patient is on opiates, please call for options, do NOT use this form without contacting pharmacy. Visit www.ldnresearchtrust.org for additional clinical resources news

Refills: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ PRN

☐ Send to **PATIENT** ☐ Charge to **PATIENT** ☐ Send to **OFFICE** ☐ Charge to **OFFICE**

SIGN HERE

_____ _____

PRESCRIBER SIGNATURE DATE

HOW TO SEND

1. Call in a prescription: (847)603-1034
2. Email prescription: ILcompoundingRx@gmail.com
3. Fax prescription: (847)232-7425
4. Upload the completed prescription order form to our website: https://illinoiscompoundingpharmacy.com/upload-prescription
5. Send Electronic ERX

Ready to Experience Personalized Care?

Take the next step toward better health with Illinois Compounding Pharmacy. Whether you're looking for custom medications, expert advice, or convenient delivery options, we're here to help

Disclaimer: Illinois Compounding Pharmacy, Inc. is a 503A licensed compounding pharmacy that customizes medications to meet unique patient and prescriber needs. The FDA allows compounding when commercial drugs are in shortage or the patient is required to take a compounded drug because they will benefit from it. Compounding a product because it is cheaper than a commercial product is not allowed. Our pharmacy does not compound copies of commercially available products unless allowed by the FDA (ie FDA shortage list, allergies, palatability, etc.