ILLINOIS COMPOUNDING PHARMACY

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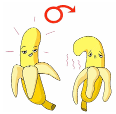
MEN'S HEALTH & UROLOGY PERSCRIPTION ORDER FORM



PATIENT INFORMATION

Patient Name:

Address:

City: State: Zip:

Phone: Allergies:

PRESCRIBER INFORMATION

Prescriber Name:

DEA: NPI:

City: State: Zip:

Phone: Fax:

TOPICAL TESTOSTERONE

*** **Note**: Testosterone is a controlled substance schedule III medication. Therefore, requires a written, fax, or electronic prescription.

☐ **Testosterone (Atrevis) Gel 100 mg/m**

Direction: Apply topically ☐ 0.25ml (25mg) 0.5ml (50mg) ☐ 0.75ml (75mg)
☐ 1ml (100mg) ☐ Other: ______ ml (______ mg) ☐ Once a day
☐ Twice a day ☐ Other: ______________

Quantity: ______________ ml Refills: ☐ # ________ ☐ As needed for 6 months

☐ **Testosterone (Atrevis) Gel 200 mg/ml**

Direction: Apply topically ☐ 0.25ml (50mg) 0.5ml (100mg) ☐ 0.75ml (150mg)
☐ 1ml (200mg) ☐ Other: ______ ml (______ mg) ☐ Once a day
☐ Twice a day ☐ Other: ______________

Quantity: ______________ ml Refills: ☐ # ________ ☐ As needed for 6 months

☐ **Other** ☐ **Testosterone Cream (Lipoderm)** ☐ **Testosterone Gel (Atrevis)**
☐ **Testosterone/ Chrysin Gel (Atrevis)**

Concentration: ______ mg/ml (If chrysin is added, specify chrysin concentration as well: ______ mg/ml)
(Note: ~200 mg/ml is the maximum concentration that can be compounded)
☐ Twice a day ☐ Other: ______________

Quantity: ______________ ml Refills: ☐ # ________ ☐ As needed for 6 months

TOPICAL TESTOSTERONE

☐ **Testosterone Cypionate 200 mg/ml Injectable (Commercial medication)**

Direction: Inject ____________ ml intramuscularly ______________
Quantity: ☐ 70 ml (7 vial) ☐ 20 ml (2 vials)
Refills: ☐ # ________ ☐ As needed for 6 months

☐ **Testosterone Enanthate/Cypionate (70:30) 200 mg/ml Injectable** *(Formula#90551)*

Direction: Inject ____________ ml intramuscularly ______________
Quantity: ☐ 5 ml (7 vial) ☐ 10 ml
Refills: ☐ # ________ ☐ As needed for 6 months

** **Prescriber Initials** ________ I am prescribing these compounds because they are clinically necessary for the treatment of this patient.

OTHER THERAPY OPTIONS

☐ **DHEA S.R. (Slow Release) Capsule**

Dose: ☐ 5 mg ☐ 10 mg ☐ 25 mg ☐ 50 mg ☐ 75 mg ☐ 100 mg
☐ Other: ____________ mg

Direction: Take 1 capsule by mouth once a day
Other: ______________________________

Quantity: ____________ Capsules **Refills:** ☐ # ________ ☐ As needed for 1 year

☐ **Anastrozole 1 mg Tablet (Commercial medication)**

(Note: Lower strength such as 0.5mg can be compounded into capsule. Please write prescription on "Other" below.)

Directions: ______________________________

Quantity: ____________ Tablets **Refills:** ☐ # ________ ☐ As needed for 1 year

☐ **Verapamil 15% - Triamcinolone 1% {lipoderm} Cream** (For Peyronie's Disease Treatment)

Directions: Apply topically twice a day as directed

Quantity: ____________ gram **Refills:** ☐ # ________ ☐ As needed for 1 year

☐ **HCG (Human Chorionic Gonadotropin) 1,000 units/ml Injectable** (Commercial medication)

Directions: Inject ________ units (______ ml) subcutaneously ______________
Quantity: ☐ 2 ml ☐ 4 ml ☐ 6 ml ☐ 7 ml ☐ 10 ml
Refills: ☐ # ________ ☐ As needed for 1 year

☐ **Clomiphene 50 mg Tablet**

Directions: Take 1-2 tablets by mouth once daily
Quantity: ☐ 60 tablets ☐ Other: ____________ tablets
Refills: ☐ # ________ ☐ As needed for 1 year

☐ **Clomiphene 25 mg - Tadalafil 5 mg Capsule**

Directions: Take 7 capsule by mouth once daily
Quantity: ☐ 30 capsules ☐ Other: ____________ capsule
Refills: ☐ # ________ ☐ As needed for 1 year

☐ **Cabergoline 0.5 mg Tablet**

Directions: Take 7 tablet by mouth twice a week
Quantity: ☐ 8 tablets ☐ Other: ____________ tablets
Refills: ☐ # ________ As needed for 1 year

CUSTOM ORDER

Medication: ______________________ Dose/Concentration: ______________________

Direction: ______________________ Quantity: ________________ Refills: ☐ # __________ ☐ As needed for 1 year

Other:	Sig:	Dispense:	Refills:

______________________ 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

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