



Main Phone: 940-484-4400
 Secure Fax: 940-898-1986

Compound RX Boric Acid

1. PATIENT INFORMATION

Patient Name _____
 Address _____
 Apt. _____
 City, State, ZIP _____
 Home Phone _____ Alternate Phone _____
 DOB _____
 Language Preference: English Spanish Other _____

2. PRESCRIBER INFORMATION

Prescriber's Name _____
 DEA _____
 NPI _____
 Address _____
 City, State, ZIP _____
 Phone _____ Fax _____
 Contact Person _____ Phone _____

3. INSURANCE INFORMATION

Fax copy of prescription and insurance cards with this form, if available (front and back)

Prescription Card: Name of Insurer _____ ID # _____ BIN _____ PCN _____ Group _____
Primary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____
Secondary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

4. PRESCRIPTION INFORMATION - Ancillary supplies and kits will be provided as needed for administration.

Boric Acid 30% / EDTA 0.5% Vaginal Gel (compound)

Quantity:

- 56 grams
 _____ grams

Sig: Apply 2 grams vaginally BID for 14 days

Sig: _____

Refills: 0 1 2 3 4 5 PRN
 (circle one)

Boric Acid 30% Vaginal Gel (compound)

Quantity:

- 56 grams
 _____ grams

Sig: Apply 2 grams vaginally BID for 14 days

Sig: _____

Refills: 0 1 2 3 4 5 PRN
 (circle one)

Boric Acid Vaginal Capsules (compound)

Quantity:

- 14 Capsules
 _____ Capsules

Sig: Insert 1 capsule vaginally at bedtime

Sig: _____

Refills: 0 1 2 3 4 5 PRN
 (circle one)

Boric Acid Vaginal Suppository (compound)

Quantity:

- 14 Suppositories

Sig: Unwrap and insert 1 suppository vaginally at bedtime (for 14 days)

Sig: _____

Refills: 0 1 2 3 4 5 PRN
 (circle one)

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Ship to: Office Patient

5. PRESCRIBER SIGNATURE - stamped signatures are **NOT** permitted

X _____ / / _____
 DISPENSE AS WRITTEN DATE

X _____ / / _____
 PRODUCT SUBSTITUTION PERMITTED DATE

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