Patient Name: _____ D.O.B: _____ Date: _____
Address: _____ Ph #: _____
Allergies: _____

Sterile Ophthalmic Preparations – To be compounded. Products not available commercially. Commercially available products not sufficient for patient treatment.

PLEASE CHECK REQUESTED COMPOUNDED PRESCRIPTION (notation of strength, quantity, directions for use may be required)

Compounded Product	Strength	Quantity
◯ Autologous serum eye drops Blood draw - required (Quantity sufficient to prepare)	20% 30% 40% 50% (Please circle one)	Quantity sufficient for **3-month** supply
◯ Autologous Plasma eye drops Blood draw - required (Quantity sufficient to prepare)	20% 30% 40% 50% (Please circle one)	Quantity sufficient for **45-day** supply
◯ Vancomycin O/S	25mg/ml **(2.5%)** 50mg/ml **(5%)**	10ml
◯ Linezolid O/S	2mg/ml	10ml
◯ Gentamicin O/S	13.6mg/ml	7ml
◯ Tobramycin O/S	13.6mg/ml	7ml
◯ Amikacin O/S	50mg/ml	10ml
◯ Cefazolin O/S	50mg/ml	10ml
◯ Ceftazidime O/S	50mg/ml	10ml
◯ Amphotericin B O/S	1.5mg/ml	10ml
◯ Caspofungin O/S	5mg/ml	10ml
◯ Voriconazole O/S	10mg/ml	10ml
◯ Mitomycin C O/S	0.2mg/ml	1ml
◯ Edetate Disodium O/S	0.37% **(0.01M)** 1.7% **(0.05M)**	10ml
◯ Glycerin O/S	50% 80%	5ml
◯ Acetylcysteine O/S	10%	5ml x 2 bottles Quantity sufficient for 28-day supply
◯ Doxycycline O/S	0.02% 0.03%	2ml x 4 bottles Quantity sufficient for 28-day
◯ Fluorouracil (5-FU) O/S	10mg/ml	5ml (28 day supply) Quantity sufficient for 4 cycles
◯ Low Dose Atropine O/S	0.01% 0.05%	Quantity sufficient for 90-day supply
◯ Hydrocortisone PF (Sodium Succinate)	0.25%	5ml

****Refills 1 2 3 4 5 prn zero**

Sig: Instill ONE drop in _____OU(both) _____OS (Left) _____OD (Right) eye _____ x Daily OR Every _____ hours.

Sig (Alternative): _____

Date/time of scheduled surgical procedure (if applicable): _____

Prescriber name/signature: _____

Clinic Phone # _____

Patient Name: _____ D.O.B: _____ Date: _____

Address: _____ Ph #: _____

Allergies: _____

Sterile Ophthalmic Preparations – To be compounded and/or drawn into unit-dosed syringes.

PLEASE CHECK REQUESTED COMPOUNDED PRESCRIPTION (notation of strength, quantity, directions for use may be required)

NOTE: Compounded formulations listed below are for intravitreal injections only – Qty 0.1ml Please document below in notes field if intrastromal injection with alternative volume is required. Additional 0.05mls overfill provided for drug loss within hub/lumen of needle.					
◯ Vancomycin INJ	1mg / 0.1ml **(Qty: 1 syringe = 0.15mls)**	**Sig: Intravitreal injection administered by qualified medical personnel only.**	**Qty Syringes**	**x 1**	**x 2**
◯ Ceftazidime INJ	2.25mg / 0.1ml **(Qty: 1 syringe = 0.15mls)**	**Sig: Intravitreal injection administered by qualified medical personnel only.**	**Qty Syringes**	**x 1**	**x 2**
◯ Dexamethasone INJ	0.4mg / 0.1ml **(Qty: 1 syringe = 0.15mls)**	**Sig: Intravitreal injection administered by qualified medical personnel only.**	**Qty Syringes**	**x 1**	**x 2**
◯ Cefuroxime INJ	1 mg / 0.1ml **(Qty: 1 syringe = 0.15mls)**	**Sig: Intravitreal injection administered by qualified medical personnel only.**	**Qty Syringes**	**x 1**	**x 2**
◯ Clindamycin INJ	1 mg / 0.1ml **(Qty: 1 syringe = 0.15mls)**	**Sig: Intravitreal injection administered by qualified medical personnel only.**	**Qty Syringes**	**x 1**	**x 2**
◯ Fluorouracil INJ	5mg / 0.1ml **(Qty: 1 syringe = 0.15mls)**	**Sig: Intravitreal injection administered by qualified medical personnel only.**	**Qty Syringes**	**x 1**	**x 2**
◯ Methotrexate INJ	0.4mg / 0.1ml **(Qty: 1 syringe = 0.15mls)**	**Sig: Intravitreal injection administered by qualified medical personnel only.**	**Qty Syringes**	**x 1**	**x 2**
◯ Voriconazole INJ	0.1mg / 0.1ml ****(Qty: 1 syringe = 0.15mls)****	**Sig: Intravitreal injection administered by qualified medical personnel only.**	**Qty Syringes**	**x 1**	**x 2**

****Refills 1 2 3 4 5 prn zero**

Sig (Alternative): _____

Date/time of scheduled surgical procedure (if applicable): _____

Prescriber name/signature: _____

Clinic Phone # _____

Notes:_____ **Qty:**_____