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

Address: _____ Ph #: _____

Allergies: _____

Sterile Ophthalmic Preparations – To be compounded. Commercial products unavailable commercially or insufficient 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 - PF Blood draw - required (Quantity sufficient to prepare)	20% 30% 40% 50% **(Please circle one)**	Quantity sufficient for **3-month** supply
◯Autologous Plasma eye drops - PF Blood draw - required (Quantity sufficient to prepare)	20% 30% 40% 50% **(Please circle one)**	Quantity sufficient for **45-day** supply
◯Amikacin O/S - PF	50mg/ml	4 x 2ml
◯Amphotericin B O/S - PF	1.5mg/ml	5 x 2ml
◯Caspofungin O/S - PF	5mg/ml	5 x 2ml
◯Cefazolin O/S	50mg/ml	4 x 2ml
◯Ceftazidime O/S	50mg/ml	4 x 2ml
◯Chlorhexidine O/S - PF	0.02%	12 x 2ml Qty sufficient for 36-day supply
◯Doxycycline O/S - PF	0.02% 0.03%	12 x 1ml Qty sufficient for 36-day supply
◯Gentamicin O/S - PF	13.6mg/ml	4 x 2ml
◯Linezolid O/S - PF	2mg/ml	4 x 2ml
◯Tobramycin O/S	13.6mg/ml	4 x 2ml
◯Vancomycin O/S - PF	25mg/ml **(2.5%)** 50mg/ml **(5%)**	4 x 2ml
◯Voriconazole O/S - PF	10mg/ml	5 x 2ml
◯Acetylcysteine O/S	10%	12 x 2ml Qty sufficient for 36-day supply
◯Atropine (Low dose) O/S - PF	0.01% 0.05%	15 x 1ml = 45-day course
◯Fluorouracil (5-FU) O/S - PF	10mg/ml	3 x 1ml = 1 week course Quantity sufficient for 4 cycles
◯Hydrocortisone (Sodium Succinate) O/S - PF	0.25%	1ml Qty sufficient per directions of use
◯Losartan O/S	0.8mg/ml	12 x 2ml Qty sufficient for 36-day supply
◯Edetate Disodium O/S - PF	0.37% **(0.01M)** 1.7% **(0.05M)** 3% **(0.089M)**	10ml
◯Glycerin O/S - PF	50% 80%	2ml
◯Mitomycin C O/S - PF	0.2mg/ml	1ml

****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 # _____

**PF indicates preservative free ophthalmic drops. Container must be discarded 72-hours after opening and stored refrigerated.

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

Address: _____ Ph #: _____

Allergies: _____

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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:**_____