

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

Address: _____ Ph #: _____

Allergies: _____

Sterile Ophthalmic Preparations – To be compounded. Commercial products insufficient for patient treatment.

Compounded Product	Strength	Quantity
<input type="radio"/> 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
<input type="radio"/> 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
<input type="radio"/> Amikacin O/S - PF	50mg/ml	4 x 2ml
<input type="radio"/> Amphotericin B O/S - PF	1.5mg/ml	5 x 2ml
<input type="radio"/> Caspofungin O/S - PF	5mg/ml	5 x 2ml
<input type="radio"/> Cefazolin O/S	50mg/ml	4 x 2ml
<input type="radio"/> Ceftazidime O/S	50mg/ml	4 x 2ml
<input type="radio"/> Chlorhexidine O/S - PF	0.02%	12 x 2ml Qty sufficient for 36-day supply
<input type="radio"/> Doxycycline O/S - PF	0.02% 0.03%	12 x 1ml Qty sufficient for 36-day supply
<input type="radio"/> Gentamicin O/S - PF	13.6mg/ml	4 x 2ml
<input type="radio"/> Linezolid O/S - PF	2mg/ml	4 x 2ml
<input type="radio"/> Tobramycin O/S	13.6mg/ml	4 x 2ml
<input type="radio"/> Vancomycin O/S - PF	25mg/ml (2.5%) 50mg/ml (5%)	4 x 2ml
<input type="radio"/> Voriconazole O/S - PF	10mg/ml	5 x 2ml
<input type="radio"/> Acetylcysteine O/S	10%	12 x 2ml Qty sufficient for 36-day supply
<input type="radio"/> Atropine (Low dose) O/S - PF	0.01% 0.05%	15 x 1ml = 45-day course
<input type="radio"/> Fluorouracil (5-FU) O/S - PF	10mg/ml	3 x 1ml = 1 week course Quantity sufficient for 4 cycles
<input type="radio"/> Hydrocortisone (Sodium Succinate) O/S - PF	0.25%	1ml Qty sufficient per directions of use
<input type="radio"/> Losartan O/S	0.8mg/ml	12 x 2ml Qty sufficient for 36-day supply
<input type="radio"/> Tacrolimus O/S - PF	0.02%	12 x 1ml Qty sufficient for 36-day supply
<input type="radio"/> Edetate Disodium O/S - PF	0.37% (0.01M) 1.7% (0.05M) 3% (0.089M)	10ml
<input type="radio"/> Glycerin O/S - PF	50% 80%	2ml
<input type="radio"/> Mitomycin C O/S - PF	0.2mg/ml	1ml
<input type="radio"/> Prednisolone/Moxifloxacin/Bromfenac	1%/0.5%/0.075%	5ml

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

Sig: Instill **ONE** drop in ____OU(both) ____OS (Left) ____OD (Right) ____ Affected eye(s) _____ 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: _____

Sterile Ophthalmic Preparations – To be compounded. Commercially available products insufficient for patient treatment.

PLEASE CHECK REQUESTED COMPOUNDED PRESCRIPTION

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.			
<input type="radio"/> 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
<input type="radio"/> 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
<input type="radio"/> 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
<input type="radio"/> 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
<input type="radio"/> 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
<input type="radio"/> 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
<input type="radio"/> 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
<input type="radio"/> 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 # _____

****Alternative volume request: If injection is intended for administration other than intravitreal (i.e. intrastromal, etc)**

Please select drug/concentration per above and adjust volume to _____ mls (plus 0.05ml overfill)