

# COMPOUNDED PRESCRIPTION ORDER FORM

## MEDICATED EYELID FORMULATIONS

### PATIENT INFORMATION

Name:		D.O.B	
Address:	City/State:		Zip:
Email:		Phone:	
Allergies:		Date Written:	

<input type="checkbox"/> <b>Biune™ Spray</b> <input type="checkbox"/> <b>Biune™ Spray Kit*</b> <i>Azithromycin Dihydrate 1% with OCuSOFT® Lid Scrub® PLUS Eyelid Cleanser</i> <b>QTY:</b> 50 mL Topical Spray Solution <input type="checkbox"/> <b>SIG:</b> One spray topically to eyelid(s) one to two times daily. *Patent-Pending Formula	<input type="checkbox"/> <b>Triune™ MAX™ Spray</b> <input type="checkbox"/> <b>Triune™ MAX™ Spray Kit*</b> <i>Azithromycin Dihydrate 1%, Loteprednol Etabonate 0.25% with OCuSOFT® Lid Scrub® PLUS Eyelid Cleanser</i> <b>QTY:</b> 50 mL Topical Spray Solution <input type="checkbox"/> <b>SIG:</b> One spray topically to eyelid(s) one to two times daily. *Patent-Pending Formula
<input type="checkbox"/> <b>Triune™ Spray</b> <input type="checkbox"/> <b>Triune™ Spray Kit*</b> <i>Azithromycin Dihydrate 1%; Diclofenac Sodium 0.1% with OCuSOFT® Lid Scrub® PLUS Eyelid Cleanser</i> <b>QTY:</b> 50 mL Topical Spray Solution <input type="checkbox"/> <b>SIG:</b> One spray topically to eyelid(s) one to two times daily. *Patent-Pending Formula	<input type="checkbox"/> <b>Demovectin™ Ointment Kit**</b> <i>Ivermectin 1%, Metronidazole 0.5%, Tea Tree Oil 0.3%</i> <b>QTY:</b> 5 g Topical Ointment <input type="checkbox"/> <b>SIG:</b> Apply one pump to eyelid margin at the base of eyelashes once daily at bedtime. *Patent-Pending Formula
<input type="checkbox"/> Alternate SIG: _____ _____	
<input type="checkbox"/> Refills: _____	
<small>*Kits include a 30-count box of OCuSOFT® Lid Scrub® Original Pre-Moistened Pads and one OCuSOFT® Premium Dry Eye Mask.          **Kits include a 30-count box of OCuSOFT® Lid Scrub® Oust™ Pre-Moistened Pads and one OCuSOFT® Premium Dry Eye Mask.</small>	

### OTHER REQUIRED INFORMATION

Medical Necessity: <input type="checkbox"/> No commercial product available <input type="checkbox"/> Patient cannot tolerate commercial formulation <input type="checkbox"/> _____
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### PROVIDER INFORMATION

Name:		NPI:	
Phone:	Fax:	Contact Person:	
Address:	City/State:		Zip:

Provider Signature:

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Dispense as Written

Substitution OK

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