COMPOUNDED PRESCRIPTION ORDER FORM
STERILE TOPICAL ANESTHETICS & POST-OP DROPS

PATIENT INFORMATION

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

❑ **TetraVisc® Plus™**
Tetracaine HCl 0.5%; Lidocaine HCl 1%
Compounded Eye Drops in Nanolast™ Ophthalmic Dispersion
QTY: 2.5 mL
❑ **SIG:** Administered by provider: Instill 1-2 drops in eye(s) prior to procedure.
*Patent-Pending Formula

❑ **TetraVisc® Plus™ Solution**
Tetracaine HCl 0.5%; Lidocaine HCl 1%
Compounded Eye Drops in Nanolast™ Ophthalmic Dispersion
QTY: 2.5 mL
❑ **SIG:** Administered by provider: Instill 1-2 drops in eye(s) prior to procedure.
*Patent-Pending Formula

❑ **Tetcaine® LD**
Tetracaine HCl 0.25%
Compounded Eye Drops in Nanolast™ Ophthalmic Dispersion
QTY: 1.5 mL
❑ **SIG:** Instill one drop in eye(s) once daily as needed, or as directed.
*Patent-Pending Formula

❑ **PREMOXIB™** ❑ **PREMOXIB™ Cataract Kit***
Prednisolone Phosphate 1%, Moxifloxacin HCl 0.5%, Bromfenac Sodium Sesq 0.075%
Compounded Eye Drops
❑ **QTY**: 8 mL ❑ **QTY**: 16 mL
❑ **SIG:** Instill ___ drop(s) in affected eye(s) ____ times a day.

❑ Additional Instructions: _____

❑ Alternate SIG: _____

_____

❑ Refills: _____

*Cataract kit includes: PREMOXIB™ Compounded Eye Drops, Fitover Cataract Sunglasses, Polycarbonate Single Eye Shield, Paper Tape (3ft) and a Zippered Nylon Bag.

OTHER REQUIRED INFORMATION

Medical Necessity: ❑ No commercial product available ❑ Patient cannot tolerate commercial formulation ❑ _____	Procedure Date (If Applicable): Deliver To: ❑ Patient ❑ Clinic ❑ Surgery Center

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

Provider Signature:

_____ _____

Dispense as Written Substitution OK

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