

Acne Compounded Medication Order Form

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PATIENT				
First name		Last name		Date of birth
Address			City, State, ZIP	
Primary phone	Secondary phone		Allergies	

ACNE FORMULATIONS	
☐ Clindamycin 1%/Benzoyl Peroxide 3% Topical Gel (PracaSil-Plus) Sig: AAA at bedtime as directed Qty: ☐ #30gm ☐ #120gm ☐ #240gm Other: _____ Refills: _____	☐ Clindamycin 1%/Benzoyl Peroxide 5%/Niacinamide 5% Topical Cream (Clarifying) Sig: AAA at bedtime as directed Qty: ☐ #30gm ☐ #120gm ☐ #240gm Other: _____ Refills: _____
☐ Clindamycin 1%/Benzoyl Peroxide 2%/Sulfacetamide 5% Topical Cream (Clarifying) Sig: AAA at bedtime as directed Qty: ☐ #30gm ☐ #120gm ☐ #240gm Other: _____ Refills: _____	☐ Clindamycin 1%/Tretinoin 0.025% Topical Cream (Clarifying) Sig: AAA at bedtime as directed Qty: ☐ #30gm ☐ #120gm ☐ #240gm Other: _____ Refills: _____
☐ Niacinamide 4% Topical Cream (Clarifying) Sig: AAA at bedtime as directed Qty: ☐ #30gm ☐ #120gm ☐ #240gm Other: _____ Refills: _____	☐ Erythromycin 3%/Benzoyl Peroxide 5%/Biotin 0.1% Topical Cream (Clarifying) Sig: AAA at bedtime as directed Qty: ☐ #30gm ☐ #120gm ☐ #240gm Other: _____ Refills: _____



1201 East Second Street
Defiance, OH 43512
Phone 419-784-4800

FAX COMPLETED FORM TO
419-784-4777

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Patient name _____ Date of birth _____

ACNE FORMULATIONS (CONTINUED)

☐ **Salicylic Acid 2%/Aloe Vera 1%/Tea Tree Oil 1% Topical Foam Cleanser**

Sig: AAA at bedtime as directed

Qty: ☐ #30ml ☐ #120ml ☐ #240ml

Other: _____ **Refills:** _____

☐ **Salicylic Acid 2% Topical Occlusaderm (Spot Isolation)**

Sig: AAA at bedtime as directed

Qty: ☐ #30gm ☐ #120gm ☐ #240gm

Other: _____ **Refills:** _____

Additional formulas are available. Please contact the pharmacist at 419-784-4800 with any questions.

PRESCRIBER

Prescriber name (print)

NPI #

DEA #

Address

City, State, ZIP

Phone

Prescriber signature

Date