

Athlete's Foot 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

ATHLETE'S FOOT FORMULATIONS	
☐ Ketoconazole 2%/Miconazole 2%/Clotrimazole 1% Topical Cream (VersaBase) Sig: AAA twice daily as needed. Qty: ☐ 30 gm Other: _____ Refills: _____	☐ Clotrimazole 2%/Ibuprofen 2%/Tea Tree Oil 1% Topical Cream Sig: AAA twice daily as needed. Qty: ☐ 30 gm Other: _____ Refills: _____
☐ Ketoconazole 2%/Tea Tree Oil 5%/DMSO Topical Solution Sig: AAA twice daily as needed. Qty: ☐ 30 ml Other: _____ Refills: _____	☐ Ketoconazole 2% Topical Foam (VersaBase) Sig: AAA twice daily as needed. Qty: ☐ 30 ml Other: _____ Refills: _____
☐ Ketoconazole 2%/Ibuprofen 2% Topical Powder Sig: AAA twice daily as needed. Qty: ☐ 30 gm Other: _____ Refills: _____	☐ Amphotericin B 3% Topical Lotion Sig: AAA twice daily as needed. Qty: ☐ 30 ml 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