

**Eczema / Atopic Dermatitis / Psoriasis**

Page 1 of 1

## Compounded Medication Order Form

|                |  |                 |                  |               |  |
|----------------|--|-----------------|------------------|---------------|--|
| <b>PATIENT</b> |  |                 |                  |               |  |
| First name     |  | Last name       |                  | Date of birth |  |
| Address        |  |                 | City, State, ZIP |               |  |
| Primary phone  |  | Secondary phone |                  | Allergies     |  |

|                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                       |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>ECZEMA / ATOPIC DERMATITIS / PSORIASIS FORMULATIONS</b>                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                       |  |
| <input type="checkbox"/> <b>Cyanocobalamin 0.07% Topical Cream (XemaTop™)</b><br>Sig: AAA topically 1-2 times daily as directed<br>Qty: <input type="checkbox"/> #30 gm <input type="checkbox"/> #60gm <input type="checkbox"/> #120gm<br>Other: _____ Refills: _____         |  | <input type="checkbox"/> <b>Zinc Pyrithione 0.2%/Clobetasol Propionate 0.05%/Cyanocobalamin 0.07% Topical Cream (XemaTop™)</b><br>Sig: AAA topically 1-2 times daily as directed<br>Qty: <input type="checkbox"/> #30 gm <input type="checkbox"/> #60gm <input type="checkbox"/> #120gm<br>Other: _____ Refills: _____                |  |
| <input type="checkbox"/> <b>Cyanocobalamin 0.07%/Urea 2% Topical Cream (XemaTop™)</b><br>Sig: AAA topically 1-2 times daily as directed<br>Qty: <input type="checkbox"/> #30 gm <input type="checkbox"/> #60gm <input type="checkbox"/> #120gm<br>Other: _____ Refills: _____ |  | <input type="checkbox"/> <b>Zinc Pyrithione 0.2%/Clobetasol Propionate 0.05%/Cyanocobalamin 0.07% Topical Gel (SpiraWash™/PracaSil™-Plus)</b><br>Sig: AAA topically 1-2 times daily as directed<br>Qty: <input type="checkbox"/> #30 gm <input type="checkbox"/> #60gm <input type="checkbox"/> #120gm<br>Other: _____ Refills: _____ |  |
| <input type="checkbox"/> <b>Cyanocobalamin 0.07% Topical Gel (PracaSil™-Plus)</b><br>Sig: AAA topically 1-2 times daily as directed<br>Qty: <input type="checkbox"/> #30 gm <input type="checkbox"/> #60gm <input type="checkbox"/> #120gm<br>Other: _____ Refills: _____     |  | <input type="checkbox"/> <b>Naltrexone HCl 0.5%/Diphenhydramine HCl 2%/Vitamin D3 5000 IU/gm Topical Cream (XemaTop™)</b><br>Sig: AAA topically 1-2 times daily as directed<br>Qty: <input type="checkbox"/> #30 gm <input type="checkbox"/> #60gm <input type="checkbox"/> #120gm<br>Other: _____ Refills: _____                     |  |

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

|                         |  |                  |  |       |  |
|-------------------------|--|------------------|--|-------|--|
| <b>PRESCRIBER</b>       |  |                  |  |       |  |
| Prescriber name (print) |  | NPI #            |  | DEA # |  |
| Address                 |  | City, State, ZIP |  | Phone |  |
| Prescriber signature    |  |                  |  | Date  |  |