

Migraine 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	

MIGRAINE FORMULATIONS	
☐ Sumatriptan 4%/Meloxicam 2%/ Topiramate 5% Topical Lipoderm Cream Sig: _____ Qty: ☐ #30 gm ☐ 60 gm ☐ 120 gm Other: _____ Refills: _____	☐ Baclofen 2%/Ketoprofen 10%/ Lidocaine 5%/Gabapentin 5% Topical Lipoderm Cream Sig: _____ Qty: ☐ #30 gm ☐ 60 gm ☐ 120 gm Other: _____ Refills: _____
☐ Ketamine HCl 5%/Gabapentin 6%/ Amitriptyline HCl 3%/Indomethacin 5%/ Tizanidine HCl 0.23%/Lidocaine 2% Topical Lipoderm ActiveMax Cream Sig: _____ Qty: ☐ #30 gm ☐ 60 gm ☐ 120 gm Other: _____ Refills: _____	☐ Sumatriptan 5%/Tramadol HCl 5%/ Gabapentin 5%/Doxepin HCl 5%/ Indomethacin 5% Topical Lipoderm Cream Sig: _____ Qty: ☐ #30 gm ☐ 60 gm ☐ 120 gm Other: _____ Refills: _____
☐ Magnesium Sulfate Heptahydrate 10% Topical Lipoderm ActiveMax Cream Sig: _____ Qty: ☐ #30 gm ☐ 60 gm ☐ 120 gm Other: _____ Refills: _____	☐ Indomethacin 10% Topical Lipoderm Cream Sig: _____ Qty: ☐ #30 gm ☐ 60 gm ☐ 120 gm 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 _____

MIGRAINE FORMULATIONS (CONTINUED)

☐ **Diclofenac Sodium 4% Topical Lipoderm Cream**

Sig: _____

Qty: ☐ #30 gm ☐ 60 gm ☐ 120 gm

Other: _____ Refills: _____

☐ **Lidocaine HCl 4%/Ketamine 2.5% Buffered Nasal Spray**

Sig: _____

Qty: ☐ #30 ml ☐ 60 ml Other: _____

Refills: _____

☐ **Lidocaine HCl 4% Isotonic Nasal Spray**

Sig: _____

Qty: ☐ #30 ml ☐ 60 ml Other: _____

Refills: _____

☐ **Riboflavin 200 mg/Caffeine 30 mg/
Ketoprofen 12.5 mg Capsules**

Sig: _____

Qty: ☐ #30 ☐ #60 ☐ #90 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