

Mouth Sores / Mucositis 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	

MOUTH SORES/MUCOSITIS FORMULATIONS	
☐ Misoprostol 0.0024%/Diphenhydramine HCl 0.1%/Lidocaine HCl 1% Oral Rinse (MucoLox) Sig: Swish and Spit 5 ml up to 4 times daily as directed. Qty: ☐ 120 ml Other: _____ Refills: _____	☐ Misoprostol 0.0024%/Ketoconazole 10 mg/ml/Tetracycline HCl 12 mg/ml/Triamcinolone Acetonide 1 mg/ml/Chlorpheniramine Maleate 0.2 mg/ml/Deoxy-D-Glucose 1 mg/ml Oral Rinse (MucoLox) Sig: Swish and Spit 5 ml up to 4 times daily as directed. Qty: ☐ 120 ml Other: _____ Refills: _____
☐ Dexamethasone 3.3 mcg/ml/Tetracycline HCl 13.5 mg/ml/Nystatin 16,667 U/ml/Diphenhydramine HCl 1.25 mg/ml Oral Rinse (MucoLox) Sig: Swish and Spit 5 ml up to 4 times daily as directed. Qty: ☐ 120 ml Other: _____ Refills: _____	☐ [Stanford Mouthwash] Tetracycline HCl 13.5 mg/ml/Nystatin 16,667 U/ml/Chlorpheniramine Maleate 2 mg/ml/Hydrocortisone 4.6 mg/ml Oral Rinse (MucoLox) Sig: Swish and Spit 5 ml up to 4 times daily as directed. Qty: ☐ 120 ml 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 _____

MOUTH SORES/MUCOSITIS FORMULATIONS (CONTINUED)

☐ [Stanford Modified Mouthwash] Tetracycline HCl 13.5 mg/ml/Nystatin 16,667 U/ml/
Diphenhydramine HCl 1.25 mg/ml/Hydrocortisone 4.6 mg/ml Oral Rinse (MucoLox)

Sig: Swish and Spit 5 ml up to 4 times daily as directed.

Qty: ☐ 120 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