

Wart Treatment 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	

WART TREATMENT FORMULATIONS	
☐ Wart Magic (Salicylic Acid 20%/Lactic Acid 10%/Formaldehyde 8% in Flexible Collodion) Sig: Apply topically to warts QHS and cover Qty: ☐ 15 ml Other: _____ Refills: _____	☐ Salicylic Acid 20%/5-FU 5% in DMSO Sig: Apply topically to warts QHS and cover Qty: ☐ 15 ml Other: _____ Refills: _____
☐ Salicylic Acid 50% in White Petrolatum Sig: Apply topically to warts QHS and cover Qty: ☐ 30 gm Other: _____ Refills: _____	☐ Cimetidine/Deoxy-D-Glucose/Ibuprofen 10%/0.29%/2% Cream Sig: Apply topically to warts QHS Qty: ☐ 30 gm Other: _____ Refills: _____
☐ Squaric Acid Dibutyl Ester 0.1% Topical Solution Sig: Apply topically to warts QHS Qty: ☐ 15 ml Other: _____ Refills: _____	☐ Dinitrochlorobenzene Ointment (circle strength) 1% or 2% Sig: Apply topically to warts QHS and cover Qty: ☐ 30 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 _____

WART TREATMENT FORMULATIONS (CONTINUED)

☐ **Diphenylcyclopropenone 0.01% Topical Solution**

Sig: Apply topically as directed

Qty: ☐ 25 ml Other: _____

Refills: _____

☐ **Cantharadin**

Sig: Apply topically as directed

Qty: _____ Refills: _____

☐ **Cantharadin Plus**

Sig: Apply topically as directed

Qty: _____ 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