



Compounded Prescription Order Form

NOTE: If you would like to request a compounded Pain Management prescription, the following are examples of available formulations. Please print out the order form and consult with your doctor. If either you or your doctor would like more information please contact Farmacia Del Pueblo and speak with our compounding pharmacists.

Patient Information

DATE _____ LAST NAME _____ FIRST _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE _____ DOB _____ ALLERGIES _____

(Check Item and Circle Strength)

Joint/Muscle Inflammation & Pain:

- _____ Ketamine 5% | 10% | other _____% in PLO Transdermal
- _____ Ketoprofen 5% | 10% | other _____% in PLO Transdermal
- _____ Ketoprofen 5% | 10% | 20% (+ Dexamethasone 0.4% in PLO Transdermal)
- _____ Ketoprofen 10% | 20% (+ cyclobenzaprine 1% in PLO Transdermal)
- _____ Flexaprofen Gel (Ibuprofen 10% + ketoprofen 10% + cyclobenzaprine 1%)

Myofacial/TMJ/Fibromyalgia Pain:

- _____ Ketamine 10% + Lidocaine 4% in PLO Transdermal
- _____ Ketamine 10% + Gabapentin 6% + Amitriptyline 2% in PLO Transdermal
- _____ Ketamine 10% + Gabapentin 6% + Baclofen 2% in PLO Transdermal

Peripheral (Diabetic or Other) Neuropathy:

- _____ Ketamine 10% + Gabapentin 6% + Clonidine 0.2% in PLO Transdermal
- _____ Ketamine 10% + Gabapentin 6% + Amitriptyline 2% in PLO Transdermal
- _____ Amitriptyline 5% + Gabapentin 3% + Lidocaine 5% in PLO Transdermal

General Pain:

- _____ Hydrocodone 10mg/ no apap. (liver protective – CII)
- _____ Hydrocodone 10 mg / 200mg apap. | Hydrocodone 10mg/ 80 mg apap.
- _____ Hydrocodone liquid (1mg/ml of hydrocodone : 50mg/ml of acetaminophen – CII)

Cluster Headache / Migraine Pain:

- _____ Lidocaine 2%|4%| nasal spray (30ml pump nasal spray bottle)
- _____ Indomethacine 25 mg | 50 mg | (rectal suppository)
- _____ Morphine Sulfate 10 mg (rectal suppository – CII)

Other formulation request: _____

(Following SIG. For topicals only)

SIG: Apply 1 gram topically to area(s) _____ Q.D. _____ B.I.D. _____ T.I.D.

Quantity: 30 Grams 60 Grams 90 Grams Refills _____

(Following SIG. For non-topicals)

SIG: _____ Qty: _____ Refills: _____

Prescriber's Signature/DEA _____ Date: _____