TOWN & COUNTRY
Compounding Pharmacy
We compound quality

Part 2 - Men's Health & Urology Prescription Order Form
Town and Country Compounding Pharmacy
535 E Crescent Ave, Ramsey, NJ 07446

PCAB ACCREDITED Compounding Pharmacy

Toll-Free Phone: 800-850-2101 **Phone**: 201-447-2020 **Fax**: 201-447-3253 **Email**: Pharmacist@tccompound.com **Website**: www.tccompound.com

Patient Name		**Prescriber Name**	
Date of Birth		Office Phone #	
Phone #		Office Fax #	
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Allergies		NPI	
Email		DEA	

2/21

Topical Testosterone

*** **Note:** Testosterone is a controlled substance schedule III medication. Therefore, requires a written, fax, or electronic prescription.

☐ **Testosterone (Atrevis) Gel 100 mg/mL** (Formula #115754)
Direction: Apply topically ☐ 0.25mL (25mg) ☐ 0.5mL (50mg) ☐ 0.75mL (75mg) ☐ 1mL (100mg) ☐ Other: _____ mL (_____ mg)
☐ once a day ☐ twice a day ☐ Other: _____
Quantity: _____ mL **Refills**: ☐ # _____ ☐ As needed for 6 months

☐ **Testosterone (Atrevis) Gel 200 mg/mL** (Formula #115838)
Direction: Apply topically ☐ 0.25mL (50mg) ☐ 0.5mL (100mg) ☐ 0.75mL (150mg) ☐ 1mL (200mg) ☐ Other: _____ mL (_____ mg)
☐ once a day ☐ twice a day ☐ Other: _____
Quantity: _____ mL **Refills**: ☐ # _____ ☐ As needed for 6 months

☐ Other: ☐ **Testosterone Cream (Lipoderm)** ☐ **Testosterone Gel (Atrevis)** ☐ **Testosterone/Chrysin Gel (Atrevis)**
Concentration: _____ mg/mL (If chrysin is added, specify chrysin concentration as well: _____ mg/mL)
(Note: ~200 mg/mL is the maximum concentration that can be compounded)
Direction: Apply topically _____ mL (_____ mg) ☐ once a day ☐ twice a day ☐ Other: _____
Quantity: _____ mL **Refills**: ☐ # _____ ☐ As needed for 6 months

Injectable Testosterone

☐ **Testosterone Cypionate 200 mg/mL Injectable** (Commercial medication)
Direction: Inject _____ mL intramuscularly _____
Quantity: ☐ 10 mL (1 vial) ☐ 20 mL (2 vials)
Refills: ☐ # _____ ☐ As needed for 6 months

☐ **Testosterone Enanthate/Cypionate (70:30) 200 mg/mL Injectable**
(Formula #90551)
Direction: Inject _____ mL intramuscularly _____
Quantity: ☐ 5 mL ☐ 10 mL
Refills: ☐ # _____ ☐ As needed for 6 months

Other Therapy Options

☐ **DHEA S.R. (Slow Release) Capsule**
Dose: ☐ 5 mg ☐ 10 mg ☐ 25 mg ☐ 50 mg
☐ 75 mg ☐ 100 mg ☐ Other: _____ mg
Direction: ☐ Take 1 capsule by mouth once a day
☐ Other: _____
Quantity: _____ capsules
Refills: ☐ # _____ ☐ As needed for 1 year

☐ **Anastrozole 1 mg Tablet** (Commercial medication)
(**Note**: Lower strength such as 0.5mg can be compounded into capsule. Please write prescription on "Other" below.)
Direction: _____
Quantity: _____ tablets
Refills: ☐ # _____ ☐ As needed for 1 year

☐ **Verapamil 15% - Triamcinolone 1% (Lipoderm) Cream**
(For Peyronie's Disease Treatment)
Direction: Apply topically twice a day as directed
Quantity: _____ grams
Refills: ☐ # _____ ☐ As needed for 6 months

☐ **HCG (Human Chorionic Gonadotropin) 1,000 units/mL Injectable**
(Commercial medication)
Direction: Inject _____ units (_____ mL) subcutaneously _____
Quantity: ☐ 2 mL ☐ 4 mL ☐ 5 mL ☐ 6 mL ☐ 10 mL (1 full vial)
Refills: ☐ # _____ ☐ As needed for 1 year

☐ **Clomiphene 50 mg Tablet**
Direction: Take 1-2 tablets by mouth once daily
Quantity: ☐ 60 tablets ☐ Other: _____ tablets
Refills: ☐ # _____ ☐ As needed for 1 year

☐ **Clomiphene 25 mg - Tadalafil 5 mg Capsule**
Direction: Take 1 capsule by mouth once daily
Quantity: ☐ 30 capsules ☐ Other: _____ capsules
Refills: ☐ # _____ ☐ As needed for 1 year

☐ **Cabergoline 0.5 mg Tablet**
Direction: Take 1 tablet by mouth twice a week
Quantity: ☐ 8 tablets ☐ Other: _____ tablets
Refills: ☐ # _____ ☐ As needed for 1 year

Custom Order

Medication: _____ **Dose/Concentration:** _____
Direction: _____ **Quantity**: _____ **Refills**: ☐ # _____ ☐ As needed for 1 year

** **Prescriber Initials** _____ I am prescribing these compounds because they are clinically necessary for the treatment of this patient.

Prescriber Signature: _____ **Date Written:** _____