NABP Accredited Compounding Pharmacy

TOWN & COUNTRY Compounding Pharmacy
We compound quality

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ACHC

Intravitreal Compound Prescription Order Form

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	
❑ Send to **PATIENT** ❑ Charge **PATIENT**		❑ Send to **OFFICE** ❑ Charge **OFFICE**	

Patient appointment date & time	Date: _____ / _____ / _____	Time: _____
Best contact person & phone # for shipping confirmation	Name: _____	Phone #: _____

NOTE

*ALL intravitreal are dispensed in prefilled syringes (1mL TB Syringe, no needle, red tip cap).
*ALL intravitreal medications are preservative-free. *Milliliter (mL) per prefilled syringe CANNOT be modified.
*Exp date is based on the date of compounding. Refer to exp date indicated on the immediate Rx label for accurate exp date.

	Intravitreal Medication	**Strength**	**Milliliter (mL) per Prefilled Syringe**	**# of Syringes**	**Exp Date / Storage (REF = Refrigerated, FZ = Frozen)**	**Formula # (Pharmacy Use ONLY)**
☐	Amikacin	400**mcg**/0.1mL	**0.8mL**	_____	3 days REF OR 45 days FZ	120278
☐	Ceftazidime	2.25% (2.25mg/0.1mL)	0.3mL	_____	3 days REF OR 45 days FZ	107850
☐	Clindamycin [1]	1% (1mg/0.1mL)	**0.8mL**	_____	3 days REF OR 45 days FZ	119649
☐	Dexamethasone [2]	400**mcg**/0.1mL	0.3mL	_____	3 days REF OR 45 days FZ	121323
☐	Ganciclovir	4% (4mg/0.1mL)	0.3mL	_____	3 days REF OR 45 days FZ	121020
☐	Methotrexate	400**mcg**/0.1mL	0.3mL	_____	3 days REF OR 45 days FZ	121244
☐	tPA [3]	250**mcg**/mL	**1mL**	_____	**** Use within 6 hours of thawing** [4]	3041
☐	Vancomycin HCl	1% (1mg/0.1mL)	0.3mL	_____	3 days REF OR 45 days FZ	93165
☐	Voriconazole	0.1% (0.1mg/0.1mL)	0.3mL	_____	3 days REF OR 45 days FZ	119977

[1] Clindamycin Phosphate; [2] Dexamethasone Sodium Phosphate; [3] tPA = Tissue Plasminogen Activator; [4] Therefore, tPA cannot be shipped overnight. MUST be picked up by physician's office or directly delivered by pharmacy driver (extra charge & may not be feasible depending on schedule).

Prescriber Signature: _____ **Date Written:** _ _ / _ _ / _ _ _ _

Toll-Free Phone: 800-850-2101 **Phone**: 201-447-2020 **Fax**: 201-447-3253

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