Publix Compounding Pharmacy #3212
HORMONE REPLACEMENT THERAPY FORM

2424 Orlando Central Parkway, Suite 200
Orlando, FL 32809
Phone: 877-253-8949
Fax: 407-965-4390

**Commercially available products may not be compounded unless there is a documented allergy/intolerance to commercial product. **

Please include this documentation as necessary.

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ________________ Patient's Last Name: ________________ Date of Birth: __/__/____ ☐ Male ☐ Female

Address: ____________________ City: ____________ State: ________ Zip: __________

Primary Phone Number: (____) ____________ Alt. Phone Number: (____) ____________ Allergies: NKDA Other: ________

This form is not valid for testosterone containing products. Please use an approved counterfeit-proof rip pad for controlled-substances.

HRT:

☐ Biest (80:20) ____________________mg
☐ (70:30) ____________________mg
☐ (60:40) ____________________mg
☐ (50:50) ____________________mg
☐ Estradiol (E2) ____________________mg
☐ Estriol (E3) ____________________mg
☐ Progesterone ____________________mg

☐ Add DHEA ____________________mg
☐ Add Other __________ + __________mg
☐ Add Other __________ + __________mg
☐ Pregnenolone ____________________mg
☐ Other ____________________mg

Dosage Form: *(Please pick one)*

☐ Capsules (SR) or (IR)
☐ Gel mg/mL
☐ Sublingual Drops *(one drop = 0.05 ml)*
☐ Sublingual Troches
☐ Suppositories
☐ Transdermal Cream mg/mL
☐ Vaginal Cream mg/gm
☐ Ointment mg/gm
☐ Other:________

Device: *(Please pick one)*

☐ Pump 0.5 mL/pump
☐ Jar ______gm
☐ Tube ______gm
☐ Click 0.25 mL/click *(topical clicks)*

Day Supply: *(Please pick one)*

☐ 30 days
☐ 60 days
☐ 90 days
☐ Other: _____days

Thyroid:

☐ Levothyroxine (T4)________________mcg
☐ Liothyonine (T3)______________mcg

Dosage Form: *(Please pick one)*

☐ Capsules (SR) or (IR)

Directions:______________________________ **Quantity:**_____ **Refills:**_______

Comments for RPh: ______________________________

Prescriber Information

Name: ____________________ DEA# ____________ NPI # ____________

Address: ____________________ City: ____________ State: ________ Zip: __________

Office Phone Number: (____) ____________ Fax Number: (____) ____________ Office Contact: ____________

Prescriber's signature: (stamps not accepted)

____________________ ☐ Substitution allowed Date

____________________ ☐ Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here:

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Please fax completed forms and all necessary documents to (407)-965-4390