

## **Compounded Formulas for Actinic Keratosis Rx Template**

Patient's Name:	DOB:		
Patient's Address:	City:	State, Zip:	
Patient's Phone:	Drug Allergies:		

## **Topical Gel/Cream Vehicle Selection**

Some of the formulas below have the option of being made as a **Cream** or as an **Anhydrous Gel**. The table below describes the fundamental differences between these two options. There are price and stability considerations with either choice.

Vehicle	Description	Price Beyond Use Dating	
Cream	White, smooth shiny cream	\$\$	Up to 30 days
Anhydrous Gel	Off white, smooth creamy gel	\$\$\$	Up to 180 days

Formulation Selection (choose by checking the box to the left of the formula)

Fluorouracil 0.5%-Salicylic Acid 10% Topical Cream or Anhydrous Gel (circle one)

Fluorouracil 0.5%-Diclofenac Sodium 3%-Niacinamide 1% Topical Anhydrous Gel

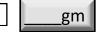
Imiquimod 5%-Diclofenac Sodium 3% Topical Cream or Anhydrous Gel (circle one)

**Quantity Selection** (choose a dispense quantity by checking the corresponding box)

15gr
1981

30	)gm
	0

45gm
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Directions for Use (Choose pre-worded directions below or manually enter directions for use)

Apply topically QHS as directed by your dermatologist				
<b>Refills?</b> Refill time(s)	No Refills	3		
Prescriber's Name:		_Date:		
Prescriber's Street Address:	City:	State:	Zip:	
Prescriber's Phone Number:	Name of perso	on submitting orde	er:	
Fax completed forms to (503)-624-0591 or email them to info@northwestcompounders.com				