Northwest Compounders
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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)

☐ 15gm ☐ 30gm ☐ 45gm ☐ ____gm

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

- ☐ Apply topically QHS as directed by your dermatologist
- ☐

Refills? ☐ Refill ____ time(s) ☐ No Refills

Prescriber's Name:_____ Date:_____

Prescriber's Street Address:_____ City:_____State:_____Zip:_____

Prescriber's Phone Number:_____ Name of person submitting order:_____

Fax completed forms to (503)-624-0591 or email them to info@northwestcompounders.com