Northwest Compounders

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# Compounded Formulas for Vaginal Atrophy or Dryness Rx Template

Patient's Name:_____DOB:_____

Patient's Address:_____ City: _____ State _____, Zip:_____

Patient's Phone: _____ **Drug Allergies:** _____

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

☐ Estradiol (E2) 0.1mg/gm-2mg/gm Topical/Vaginal Cream _____(write-in strength)

***Prescribers: If you are prescribing compounded estradiol topical/vaginal cream, please provide a medical rationale that states why Estrace© is not an appropriate treatment option for this patient:

_____

_____

i.e. "patient is allergic to inactive ingredients in Estrace©" note-> Cost is not considered a valid rationale

☐ Estradiol (E2)-Estriol (E3) 50:50 1mg/gm Vaginal Cream

☐ Estradiol (E2)-Estriol (E3) 50:50 1mg/gm Vaginal Gel

☐ Estriol (E3) 0.025% to 1% Topical/Vaginal Cream _____(write-in desired strength)

☐ Estriol (E3) 0.05% Vaginal Gel

☐ Estriol (E3) 1mg Vaginal Suppository

☐ Estriol (E3) 0.1%-Progesterone 3% Vaginal Gel

☐ Estriol (E3) 1mg-Progesterone 30mg Vaginal Suppository

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

☐ 30 each ☐ 60 each ☐ 90 each ☐ ____each

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

☐ Use applicator to insert 1mL vaginally TIW QHS

☐

## 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**