



Compound Care Plus Pharmacy

Please Print out, Complete,
and Fax to:
866-832-2264



Iontophoresis Compound Order Form

Date: _____ Physician Name: _____

Facility Name: _____ Physician DEA: _____

Shipping Address: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Physician Signature: _____ **Refills:** _____

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ ST: _____ Zip: _____

Telephone: () _____ Allergies: _____

<i>Product</i>	<i>Strength</i>	<i>Package Size</i>	<i>Quantity</i>
Dexamethasone Sodium Phosphate Solution	0.4 %	2 oz 4 oz 8 oz 12 oz 16 oz	
Acetic Acid Solution	4.0 %	2 oz 4 oz 8 oz 12 oz 16 oz	
Ketoprofen Solution	10 %	2 oz 4 oz 8 oz 12 oz 16 oz	
Lidocaine Solution	4.0 %	2 oz 4 oz 8 oz 12 oz 16 oz	
Gabapentin Solution	6.0%	2 oz 4 oz 8 oz 12 oz 16 oz	
Baclofen Solution	0.5 %	2 oz 4 oz 8 oz 12 oz 16 oz	
Other:			

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