

*Please provide patient information and check requested compounded prescription of choice.
Medical Provider signature needed at bottom.*

FAX FORM TO 206.782.1499

Pet's Name: _____ Owner: _____ Phone: _____

Address: _____

Species: _____ Disease States: _____

SHIPPING	<input type="checkbox"/> Courier <input type="checkbox"/> USPS Ground <input type="checkbox"/> Pickup <input type="checkbox"/> _____	PAYMENTS	Credit Card#: _____
	Address: _____		Exp Date: _____ CVV: _____
	City: _____		Cardholder Name: _____
	State: _____ Zip: _____		Billing Zip: _____

DRUG

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Acepromazine | <input type="checkbox"/> Captopril | <input type="checkbox"/> Fluoxetine | <input type="checkbox"/> Piroxicam |
| <input type="checkbox"/> Acetylcysteine | <input type="checkbox"/> Clindamycin | <input type="checkbox"/> Gabapentin | <input type="checkbox"/> Potassium Bromide |
| <input type="checkbox"/> Aluminum Hydroxide | <input type="checkbox"/> Clarithromycin | <input type="checkbox"/> Itraconazole | <input type="checkbox"/> Prazosin |
| <input type="checkbox"/> Aminophylline | <input type="checkbox"/> Clomipramine | <input type="checkbox"/> Levetiracetam | <input type="checkbox"/> Prednisone |
| <input type="checkbox"/> Amitriptyline | <input type="checkbox"/> Cisapride | <input type="checkbox"/> Maropitant | <input type="checkbox"/> Prednisolone |
| <input type="checkbox"/> Amlodipine | <input type="checkbox"/> Cyproheptadine | <input type="checkbox"/> Methimazole | <input type="checkbox"/> Pyridostigmine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Cyclosporine | <input type="checkbox"/> Metoclopramide | <input type="checkbox"/> Sildenafil |
| <input type="checkbox"/> Atenolol | <input type="checkbox"/> Digoxin | <input type="checkbox"/> Metronidazole | <input type="checkbox"/> Spironolactone |
| <input type="checkbox"/> Azathioprine | <input type="checkbox"/> Doxycycline | <input type="checkbox"/> Mexiletine | <input type="checkbox"/> Sulfamethoxazole |
| <input type="checkbox"/> Azithromycin | <input type="checkbox"/> Enalapril | <input type="checkbox"/> Omeprazole | <input type="checkbox"/> Trilostane |
| <input type="checkbox"/> Benzazepril | <input type="checkbox"/> Estriol | <input type="checkbox"/> Pentoxifylline | <input type="checkbox"/> Tylosin |
| <input type="checkbox"/> Budesonide | <input type="checkbox"/> Famotidine | <input type="checkbox"/> Phenylpropanolamine | <input type="checkbox"/> Ursodiol |
| <input type="checkbox"/> Buspirone | <input type="checkbox"/> Fluconazole | <input type="checkbox"/> Phenoxybenzamine | <input type="checkbox"/> Zonisamide |
| <input type="checkbox"/> Calcitriol | <input type="checkbox"/> Furosemide | <input type="checkbox"/> Pimobendan | |

Please ask for medications not listed.

Form

- Flavored Suspension
- Flavored Chewable Treats
- Flavored Mini Chews
- Oral Capsules
- Topical Transdermal Gel
- Rectal Gel
- Suppositories

Strength

- _____ mg
- _____ mg/ml
- _____ ng
- _____ ng/ml
- _____ other: _____

Flavor:

SIG: _____

Quantity: _____ **Refills:** _____

Written for: As Indicated Above: _____	Directions: As Indicated Above
Medical Provider: _____	Phone: _____
Address: _____	Email: _____
_____	_____
(Medical Provider Signature - dispense as written)	(Medical Provider Signature - substitution permitted)

To process this Compounded Prescription request, please sign and fax to: **AXIS Pharmacy NW** at 206.782.1499 or pharmacy of patient's choice.

This form does not meet the requirements of Washington State's Tamper-Resistant Prescription Paper Law (RCW 18.64.500) and is legal only when faxed to the pharmacy from the prescribers office.