axis™
Pharmacy Northwest

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Mountlake Terrace, WA 98043 | 425.672.5820

VETERINARY COMPOUNDING SERVICES

Methimazole TD-GEL

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

❑ Courier ❑ USPS Ground ❑ Pickup ❑ ______________

____

Address: ______________

City: ______________

State: ______________ Zip: ______________

PAYMENTS

Credit Card#: ______________

Exp Date: ______________ CVV: ______________

Cardholder Name: ______________

Billing Zip: ______________

❑ **Methimazole 25MG/ML Transdermal Gel**
SIG: Gently massage 0.1ML (2.5MG) to alternating inner ear surface ONCE a day (WEAR GLOVES)
Quantity: 3ML (1 month) 6ML (2 months) 9ML (3 months)
Refills: ______________

❑ **Methimazole 25MG/ML Transdermal Gel**
SIG: Gently massage 0.1ML (2.5MG) to alternating inner ear surface TWICE a day (WEAR GLOVES)
Quantity: 6ML (1 month) 12ML (2 months) 18ML (3 months)
Refills: ______________

❑ **Methimazole 50MG/ML Transdermal Gel**
SIG: Gently massage 0.1ML (5MG) to alternating inner ear surface ONCE a day (WEAR GLOVES)
Quantity: 3ML (1 month) 6ML (2 months) 9ML (3 months)
Refills: ______________

❑ **Methimazole 50MG/ML Transdermal Gel**
SIG: Gently massage 0.1ML (5MG) to alternating inner ear surface TWICE a day (WEAR GLOVES)
Quantity: 6ML (1 month) 12ML (2 months) 18ML (3 months)
Refills: ______________

❑ **Methimazole _____ MG/ML Transdermal Gel**
SIG: Gently massage 0._____ML (_____MG) to alternating inner ear surface ______________ a day (WEAR GLOVES)
Quantity: 3ML 6ML 9ML 12ML 18ML _____ML
Refills: ______________

Written for: As Indicated Above: ______________ Directions: As Indicated Above

Medical Provider: ______________ Phone: ______________

Address: ______________ Email: ______________

______________ ______________

(Medical Provider Signature - substitution permitted) (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.