

*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: \_\_\_\_\_

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