

*Please provide patient information and check requested compounded prescription of choice.*

**Medical Provider signature needed at bottom.**

**FAX FORM TO: 425.672.5821**

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"/> _____	<b>PAYMENTS</b>	Credit Card#: _____
	Address: _____		Exp Date: _____ CVV: _____
	City: _____		Cardholder Name: _____
	State: _____ Zip: _____		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: _____	Date: ____ / ____ / _____
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.*